THE CANADIAN NURSE

ME 52 NUMBER 11
MONTREAL

Highlight for
OVEMBER 1956

NVENTION ADDRESSES

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MARTELLO TOWER

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THE CANADIAN NURSE

L'Infirmière Canadienne

VOLUME 52 **NUMBER 11**

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Between Ourselves

WITH THIS ISSUE, the publication of addresses given at the 1956 Biennial Convention in Winnipeg is completed. It has been a very worthwhile series. It is our hope that every nurse will avail herself of the opportunity to study these outstanding papers.

* * *

Reports reaching us of student enrolments in the new classes entering our schools of nursing this fall seem to indicate that the activities of the Student Recruitment Committees are paying dividends. Numbers of schools have reported capacity classes.

Beginning this year, a large proportion of the directors of nursing have been availing themselves of the offer, made by the Editorial Board of *The Canadian Nurse*, to present a complimentary subscription to the student who receives the highest standing in theory and practice during her preclinical period. When a school takes only one class in each year the award subscription runs for two years. When there are two classes, the subscription period is divided between the two winners, each receiving the Journal for one year.

It occurs to us that here is a very tangible way in which graduate subscribers could extend a helping hand to the youngsters. If you remember back to your own student days many of you will doubtless recall that there wasn't too much money in your personal bank account. The $5.00 that would pay for a three-year subscription to *The Canadian Nurse* was needed for a dozen other purchases. Besides, why subscribe? "There's a copy in the library!"

Most of today's student nurses are just as hard pressed to make ends meet for personal expenditures as we were. Many of them who would like to receive their own copies of the Journal put it off until later for financial reasons. So here is our thought — how about "adopting" a preliminary student of your own school of nursing or in the hospital where you are working and giving her a subscription to the Journal as a Christmas present?

If you know the name and address of the student you would like to assist in this way, send your order to us. We will send a gift card at Christmastime telling her about it. If you would like to make such a Christmas donation but do not know the name of a preliminary student, send us your cheque. We will write to the school of nursing of your choice and ask the director of nursing to select a deserving recipient. Let us hear from you.

* * *

While we are on the subject of gift subscriptions, you may be interested to know that several nurses have asked us to transfer their subscriptions to nurses in some foreign country who are unable to send money out. We wrote to Miss Helen McArthur for suggestions regarding Korean nurses. She gladly supplied some names.

Most of the subscriptions to foreign nurses that were started through the gifts you made to the War Memorial of the Canadian Nurses' Association are now terminating. Regretfully, many of these nurses have written us that though they shall miss the regular copies, they cannot pay for renewals. Here is another place you might put that $5.00 that is burning a hole in your wallet!

Do you know the difference between the lengths of Canadian and American sheets? To help avoid confusion in the buying of sheets, remember that "Torn Length" is the American basis of marking: "Hemmed Length" is the Canadian basis. If you buy a sheet with U.S. marking, you should subtract about five inches (5") from the listed length to have a sheet comparable with the Canadian length, measured *after* hemming.

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N.C. in *Saturday Review*

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Edited by DEAN F. N. HUGHES

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Improving Nursing Service

MARGARET G. ARNSTEIN, M.A., M.P.H.

I CHOSE THE SUBJECT of my talk to remind myself that there is something in life besides studies, that things can be accomplished without necessarily doing a study first. There is a danger of forgetting this when one is immersed in studies and observes, time after time, how they contribute to action programs. There are those who think that we are study mad in the United States. I suspect that you may have a more balanced approach to the values of research. Still, it may be of interest to you to examine with me some of the things currently being done to improve nursing service and the place of the study in the total pattern.

We are constantly changing various aspects of our nursing services and, we hope, improving them. Alterations are necessitated by changes in medical science and practice, by changes in the society we serve, and changes in ourselves who are part of this society. Medical science has made such startling advances in the last 15 to 20 years that the whole picture of sickness and health has undergone a profound alteration. You are familiar with these things — the diminishing importance of the acute communicable diseases, at least as a cause of death; the effect of the antibiotics on the recovery of people suffering from all types of infections, the advances in surgery.

Radical changes in nursing practice have been required as a result of these developments, which also have been the cause of some of the most significant social changes. Greater success in hospital treatment has increased the use of our hospitals and, consequently, the demand for more hospital beds. Reduction of mortality in the younger age groups has increased the number of older people and it also has increased the numbers needing rehabilitation. Many who once died now live with some impairment and the extent to which this interferes with normal living depends partly on the success of rehabilitation.

Other social changes have also influenced nursing — the shorter work week, the higher proportion of young

Miss Arnstein is Chief, Division of Nursing Resources, United States Public Health Services, Washington, D.C.

people finishing high school and going to college, the acceptance of the philosophy of insurance against disasters of all kinds including sickness, and the trend toward increased specialization.

It may be partly this pressure to change, the rapidity with which we have *had* to change, that has made us so aware of the need to improve. We have had no chance to settle into a comfortable "usual" way of doing things.

Many of the important changes and improvements have come about not because of formal studies but because some person, or a group of people, thought it would be better to do something a new way. This thought comes from somewhere — from a series of observations made more or less subconsciously during the day's routine; observations of gaps in service; of needs for better nurse-patient relationships or more adequate teaching. These things are not formally recorded or added up on paper, but accumulate in one's mind so convincingly that they constitute a basis for action.

Take, for example, *team nursing*. My examples will have to come from our experience in the States. If they do not fit your experience, I hope you can supply examples of your own. The important features of team nursing are:

> It provides a medium through which *all* nursing personnel may readily exchange information about the patients under their care. Team nursing relieves the head nurse of the burden of individual assignments and the individual supervision of each member of the nursing staff, a sometimes wasteful application of her skills.
>
> Each group of patients has an opportunity to know the members of the team assigned to that group, and is not forced into adjusting constantly to different personalities with different techniques and skills.

The person or persons who first proposed team nursing observed that ancillary personnel usually had no chance to listen to the morning or evening reports of the condition of patients in their unit. Neither was there any other planned way to inform them about the patient's progress during the previous eight hours. Yet these auxiliary personnel were expected to give nursing care — and they ***were*** giving it — completely in the dark, with no real knowledge of the patients' needs.

It could also be seen that many people were coming to the head nurse bringing requests and asking, "What do I do next?" The head nurse did not have time to give any of them her full attention. She was also assigning many duties without any over-all plan, meeting each need as it arose. Thus, each patient might be cared for by every member of the nursing staff in one day.

These imperfections in relationship between nursing service personnel were noted on separate occasions and not spelled out in sequence as I have done here. However, the facts and their implications were put together. A way of overcoming the difficulties was worked out and this method has been labeled "team nursing.' '

In the same manner, nurses have improved nursing service in the hospital and the home in hundreds of ways. They found ways for small, slender young women to turn large men in bed with ease and comfort to the patient; they found ways to support a patient on his side so he felt secure; they improvised backrests in the home from kitchen chairs, they devised ways to keep covers off the patient's injured part; they have constantly improved their methods of preventing bed sores. I could go on and on, but there is no need to for you can supply from your experience other examples of improvement in nursing service which have been achieved without a planned study but not without studying the situation.

Having decided that a certain course of action is desirable, how does one bring it about? *By group participation in group decision.* There are studies that give strong support to this method of bringing about change in the behavior of groups. I came across one method recently that had been made in a pajama factory.

> Management methods had to be changed frequently. The changes were routinely explained to the employees by a man from the "front office." Invariably, a large number of workers quit rather than alter their work habits. Those who stayed on the job never made

their work quotas and had more difficulty learning the new methods than did new employees. As a remedy, the company decided to let the employees share in the process of making decisions. This participation was made available in different ways. One group was permitted to appoint a committee to decide how, when, and where a job would be altered. A second group studied the job together and, on the basis of what management had conveyed to them of emerging needs, they made group decisions on new methods of work. A third group remained on the old system of "briefings only" from the management office.

When the results were analyzed, it was found that Group One — those who appointed a committee — were no less productive than formerly and had learned the new work method with relative ease; the percentage of workers who quit was low. Group Two — those who were permitted optimum participation in planning for the change — learned the new methods in amazingly little time, their turnover rate was negligible, and their rate of production was considerably higher than formerly. I need not add that Group Three showed evidence of the same destructive negativism — high turnover, slow learning capacity, and inadequate productivity.

Before going on to discuss the use of studies as a means of effecting improvement in services, I should like to recapitulate. Change can be brought about by common sense and insight, or by applying the knowledge obtained through experience. During either of these efforts to cause constructive change, we are actually going through most of the steps of a formal study without being aware of it. We are identifying needs, or gaps in program. We are collecting data — commonly called learning through experience. We are making decisions, using our faculty of judgment. We are solving problems.

In order to solve a problem we must first recognize that it exists. When we are not engaged in a formal study, we may by-pass the difficult job of defining the problem in exact terms and go on to making observations of our own — or learn by reading the results of someone else's observations. More often than not, these are "impressions" rather than conscious or planned observations, but because they are the outgrowth of experience they serve as a basis for deciding what needs to be done. The group shares in deciding on a course of action and then helps in formulating the action program.

If we can make improvements in nursing service in this manner, why do we bother with time-consuming, and often costly, formalized studies? When and why do we decide to conduct a study to see how we can improve services? We may undertake a study because the previous efforts to improve service have not given us the results we hoped for. We may need more penetrating information than can be obtained from casual consideration of the facts, or even from careful personal analysis of any given situation. Some other reasons are:

1. A study will give us new information — facts not known to anyone before, facts that have general application.
2. It can give us facts about a particular situation.
3. It can give us facts that may be fairly obvious to some people but are not recognized or accepted by the group doing the study. Thus it serves to give people a new look at a familiar situation.
4. A study can also serve as a motivating force to change. This is more likely to happen if the people who have to make the change participate in making the study.

I am limiting this discussion to social studies, the type most frequently used as a basis for improving nursing service. I shall not discuss laboratory or even strictly clinical studies, though certainly my first two points apply to all studies.

I was asked to describe some of the studies we have been doing in the Division of Nursing Resources. You may be interested in the study method we have developed for studying the time distribution of the activities of all nursing personnel on a patient unit. This study is very similar to your head nurse study. The general problem was the same as the one stated in your study, "shortage of nurses," and reflected the need for those who were available to use their time as efficiently as possible.

Only certain aspects of total job effectiveness are included in this study

method. One aspect to be studied is the amount of time each nurse is spending with patients — or in their presence. This latter item was included because we were constantly hearing from patients how seldom they saw a nurse. This seemed like a legitimate complaint which should be explored further, inasmuch as we were all in agreement that the very essence of nursing care is the nurse-patient relationship. Another important aspect of job effectiveness covered in this study is the extent to which each worker is performing the tasks which are proper to her job.

This study, described in our manual entitled, "How To Study Nursing Activities in a Patient Unit," was designed to point up facts not readily recognized or accepted and to motivate people to change. So that hospitals could make the study themselves, the manual describes the method, step by step, from the first desire to make the study to the final step of preparing the report. The manual includes also a brief suggestion on how to initiate action following the study.

Because we thought that involvement of the nursing staff was essential if action were to result, the manual suggests not only that the purpose of the study be discussed with the entire staff but that the observers be members of the hospital staff. The training the observers receive — first, in understanding the definitions and the reasons for the classifications used, and secondly, in the actual process of observing and recording and classifying activities — has proven so valuable that often nurses who are not to be observers in the study have also participated in the training program. We recommend about 14 hours of training which includes group discussion and a two-hour practice period on the wards.

You may be interested to hear some of the results of nursing activity studies that hospitals in the United States have made to date. I have selected just a few examples of the kinds of action which have occurred.

Many of the hospitals reported that when they were able to relieve their head nurses of non-nursing duties, job satisfaction increased noticeably among the entire staff. One hospital found that by better utilization of nursing personnel they could open two new floors without employing additional nurses. Complaints about work pressures were universally reduced. Head nurses found they were able to spend more time in supervisory activities and staff nurses received guidance when they needed it. The effects of the studies were apparent even in the schools of nursing. In several instances, the faculties of nursing schools were able to use the study findings to teach students how to organize their work assignments; this produced greater satisfaction for them as they were consequently able to spend more time on activities with patients.

The majority of hospitals agree with us that it is important to re-study in order to measure accurately the amount of change occurring following the initial study. Frequently, a "feeling of improvement" prevails just from doing a study. While this is healthy, it is even better to know exactly what has resulted from a study.

Studies of the distribution of nursing time merely set the stage for improvement of the quality of nursing care of the patient. These time studies tell us how much time the nurse is spending with the patient and may even tell us what she is doing. They do not tell us how she is doing it. In most cases the nurse's presence will reassure the patient, her ministrations will benefit him, but often not to the extent she might if she had more understanding of the patient's needs. Occasionally she may even do harm to the patient.

A patient in a medical unit had a very unstable blood pressure. Sharp rises were always accompanied by severe headaches and nausea. The occurrence of these increases in blood pressure baffled the doctors because they were not correlated with change of medication or activity. The head nurse on the unit observed that a certain staff nurse was always in attendance when these episodes occurred. Inquiry revealed that this nurse upset the patient. "In fact" the patient said, "I don't think she believes I am suffering as much as I am." The nurse was reassigned as an experiment. It worked. The capricious blood pressure rises stopped immediately.

Although this situation is rare, in a much less harmful manner it may occur and not even be recognized

whenever nurses acquire extra time to spend with patients and do not know how to spend it profitably. Most hospitals that have done time studies now recognize the value of providing in-service instruction to help the nursing staff learn how to spend their time with patients to best advantage.

We have some knowledge of the patient's needs and which of these can be supplied by nursing service. We need much more information and understanding of this whole area. So far, we have very little knowledge on how to help the nurse meet these needs of patients. Marion Cleveland, director of nursing at Presbyterian Hospital, New York, said a few years ago that sometimes it seemed as though we were nursing the equipment attached to the patient instead of the patient.

If we were given the opportunity of choice, could we ever choose to nurse the patient's anxieties instead of following techniques, if both could not be done? Many times we could not, for if we delayed keeping the various suctions operating properly we might kill him at once. But perhaps there are times when we could. Dr. Hargreaves, director of Mental Health in WHO, once said he would rather have mothers take care of their children in hospital and risk a few infections from faulty technique than risk what he thought were much greater chances of impairing the child's emotional health if he were separated from his mother.

We need much more information in the whole area of the effect of emotion on health and the role the nurse can play in this scene, in view of the many demands not only on her time but also on her intellectual and emotional capacities.

We nurses are in an excellent position to make the observations that will lead to conclusions in studies of this type for, whether we are with the patient 30 per cent or 50 per cent of our day, we are with him more than any other group. We need not start with a big world-shaking study. We can do something as simple as developing an experiment with different kinds of early ambulation, for example. We could try out short and frequent periods out of bed in contrast with longer and fewer ambulatory incidents. Then we could test the effects of both on the patient's pulse and blood pressure, observe any evidence of fatigue, and note his verbal responses about being up. The conclusions from the recorded observations should give us some interesting clues to the relationship of nursing to patient welfare, both emotional and physical.

I have purposely mentioned a very simple study to demonstrate to you the fact that valuable data may be collected within the framework of everyday nursing experience.

When we say we need more nurses, do we know what we need them for? Some hospitals are so short that they need more nurses in order to have one nurse on duty in each area for the full 24 hours. Others know that medications are given late, treatments delayed because of lack of staff, etc. But other hospitals which meet these basic requirements also say they need more nurses. When asked for specific examples of things that are not being done, many hospitals can answer only in generalities. Hospitals with relatively large numbers of nurses per patient were crying "shortage" as loudly as their neighbors with much lower nurse-patient ratios.

For these reasons, we are now in the process of conducting a study in 60 hospitals to find out whether there is any correlation between hours of nursing care and number of deficiencies in nursing service. This has a very negative sound, but we want to find out what is *not* getting done that might be done if there were more nurses. We have tried to get a record of events as patients, nurses and doctors perceive them. While this method is more subjective than if we used observers, it was the only practical one we could develop that could be done by hospitals themselves. It also fitted the objectives of the study, for the pressure for more nursing service comes not only from patients, but also from the perception of care by the nursing service and medical personnel.

The questionnaire is simple and has been filled out without difficulty by 20,000 people. The development of the questionnaire, however, was not simple. It took us over a year! Research is like the iceberg — two-thirds invisible.

Research is also international and

in our study designed to diagnose the ills of an outpatient department we drew heavily on the experience of Mr. H. A. Goddard and his associates in England.

Research is never finished. Our understanding of the why of living matters is very meager still. Research in a basic science presents new problems to a related applied science and generates the need for more research. Man's curiosity — and certainly woman's — is never satisfied. Research has been defined as seeking the answer to a question pressing for solution. Research in nursing is only beginning.

We can look forward to a long line of nurses stretching far into the future, seeking answers to the questions we have and to many we have not dreamed of yet. Let us hope that thoughtful, inquiring minds will be given encouragement and the full support, not only of the nursing professions, but also the other professions with whom they work.

Research is not new in nursing. Florence Nightingale made careful studies of nursing a hundred years ago when she started the profession. May her research lamp, as well as her lamp of comfort, continue to inspire us.

In the Good Old Days

(*The Canadian Nurse* — NOVEMBER, 1916)

A study of 403 applicants for practical nurse work showed that the rejected probationer is by all odds the most difficult type to deal with. She has been long enough in a hospital to acquire certain habits so overestimates her worth, objects to housework, wants to wear white dresses on duty, be called a "trained nurse" and is generally insubordinate. Most of these workers wanted from $20 to $25 a week for their services instead of the $2.00 a day they are permitted to charge.

* * *

A fundamental need of nurses is education, liberal education. We readily believe it as a theory but stumble at its practice for we know there is and always will be more nursing needed than can be done by only the highly efficient. The need is for a more pronounced *grading of nurses*. School teachers with second class certificates secure their first class standing, with its increased salary, only by proving their natural talent, applying themselves and spending their money to improve themselves. Why not require a similar talent, application and expense test for nurses?

* * *

Until recent years, it was considered that the country with the highest infant mortality was the most fortunate. How frequently one still hears the assertion that delicate infants should not live; that efforts directed along this line are futile; that hospitals for the saving of sick children are but misguided philanthropy . . . Child welfare nurses spend much of their time combatting these misconceptions. Most of those sickly infants were healthy at birth and are victims of bad environment, poor feeding and neglect.

* * *

"How are we going to prevent our country from being swamped with foreign nurses when this war is over?" writes one nurse serving overseas with the C.A.M.C.

Poliomyelitis

The outlook in poliomyelitis, both immediate and long range, appears favorable, according to the statisticians of the Metropolitan Life Insurance Company. Through the first eight months of 1956, reported cases of the disease in the United States were 45 per cent fewer than in the comparable period of last year.

An outstanding feature of the long-term poliomyelitis trend, say the statisticians, is a pronounced shift to the older ages. The disease now claims more of its victims among older children and among adults up to age 35 than it formerly did.

The shift in the age pattern may result primarily from a rise in the age at which natural immunity is acquired, possibly reflecting lessened frequency of exposure among children. A sharp drop in 1955 in the frequency of hospital admissions of cases with paralytic poliomyelitis at ages 7 and 8, it is noted, coincided with the wide use of Salk vaccine at those ages.

Creative Nursing

MILDRED E. SCHWIER, M.A.

THE NATIONAL LEAGUE FOR NURSING has as its major purpose the betterment of nursing for people through the promotion of improvement in nursing service and nursing education. I have been invited to report to you on some of the progress being made by schools of nursing in their efforts to assist nursing students to become prepared to give better care, especially progress which relates to the objectives of schools.

Identifying and stating objectives for a school and using them as a basis for curriculum developments are not new activities. Florence Nightingale stated objectives for nursing and for nursing education. In her *Notes on Nursing* subtitled: "Nursing — What It Is and What It Is Not," in *The Art of Nursing*, and elsewhere she projected stated objectives, indicating the kind of behavior to be achieved by nursing students through the educational program.[7,8] Why then are present-day nurse educators so concerned about the objectives in our schools of nursing? Is it because we are required to state our aims by legal or voluntary accrediting bodies? Is it because we have more sophistication about educational practices in other disciplines and are following the crowd? We hope not and believe not.

We believe that this concern emerges from a greater recognition of the fact that the quality of education for nurses today controls the kind of care our patients will receive tomorrow; from a greater understanding on the part of many practitioners of what nursing is and what it ought to be; and from a deeper insight into the relationship of objectives to the total program and the future behavior of the nurse. We are recognizing that objectives need constant evaluation as Robert Doherty has stated: "Education is not a static thing. Neither subject matter nor method can become frozen for long periods without imposing almost treasonable injustice on coming generations.[1]" For us, the term "'coming generations" means both nurses and patients.

Nurse educators who are trying to state objectives as a basis for helping students to learn to give better care to patients seem to be asking such questions as "If I had heart disease, arthritis, tuberculosis, cancer, how would I like my nurse to feel and act? Would I like her to resemble nursing students who say:

> It's boring to nurse patients with long-term illnesses. The sum total of this kind of nursing care is routine. Nothing dramatic ever happens.
>
> There is so little satisfaction when you can't see patients improving day by day. Every morning when you go into the nursing unit the patients are still in bed and they certainly are not looking any better.
>
> If I had a choice, I wouldn't work on a service where there are patients who have chronic diseases.
>
> We found that many graduate nurses don't like this kind of service, either. They just wait around in departments where there are long-term patients until there are openings in the departments of their choice.
>
> One graduate nurse likes it, though, because it is so easy. There are not many bed baths. She just has to make some beds.

Or, would I, on the other hand, like her to resemble students in another group who had different objectives, different learning experiences, different teaching, and who reacted in this manner:

> It's a terrific challenge to work with patients who have long-term illnesses. Keeping these patients contented and happy and progressing — that's something to put your teeth into.
>
> More than in any other situation we became involved with patients. We were

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Miss Schwier is Director, Department of Diploma and Associate Degree Programs, with the National League for Nursing. This address was given during the nursing education program at the recent Biennial meeting.

so anxious to see them better in every respect, physically as well as mentally, that we wanted to do anything we could to help them.

It was such a satisfying experience because we got a chance to use so many kinds of skills, social and psychological, with the patients.

We learned so much during this experience. Nowhere else is the "patient as a whole" approach so clear and vivid. And learning to be patient and bide your time before doing the many things you think ought to be done but for which the time isn't quite ripe enough — that is something important to learn!

It's the future I keep thinking of and of what could be done in oh! so many ways. Take tuberculosis nursing. Think of what waits to be done — teaching the public, teaching kids in high school, standardizing precautionary measures so that patients who have been in several institutions will accept them. The future is tremendous.[8]

The very terms used in nursing literature in the past decade and a half suggests a growing concern with what nursing is or ought to be. They include rehabilitative nursing, comprehensive nursing, total patient care, creative nursing. They imply that nurses should be able to help patients to restore themselves physically and mentally; that they should understand and be able to meet all the nursing needs of people, specified and implied; that they should understand the relationship of facts to each other and to action; that they should work with thought and imagination, interpreting along new lines which they invest with form and character. These concepts hold many implications for nursing education and have real meaning for those who are attempting to identify and utilize objectives.

The thoughtful nurse educator working in a school that says its objective is "to prepare well-rounded nurses for a fine profession" finds little in it beyond the intuitive to guide her or her students toward changes in behavior. She does, however, see in it a need, pointed out by Ole Sand, for moving this statement from the intuitive to the explicit through creative thinking.[9] As a result, much action is taking place in the re-examination of the objectives and in the concomitant reconstruction of the curriculums of educational programs in nursing.

Information gathered through the NLN school improvement program reveals that many schools had no stated objectives in 1951. Since then, their faculties have been working continuously to identify and state objectives in clear and meaningful terms. Objectives of some schools, that have been gathering dust since the late Nineteenth Century, have been unearthed and scoured and are in process of being made useful. The objectives of other schools are undergoing systematic study because they are fundamental to research that is being done on the curriculum. For instance, the faculty of the University of Washington School of Nursing, involved in such research, found that some objectives were suitable and were being stressed sufficiently; it also found gaps between what students were doing and what they should do to meet the demands of society.

Faculties like the one at the University of Washington are in a more fortunate position than most. Generally speaking, the nurse leaders and teachers are better prepared for this job academically and by experience than are the faculties of many of our hospital schools; the students can readily be given opportunity to become involved in a cooperative relationship in the study of curriculum. Resource persons from other disciplines may be more easily available. There is money to support the project. The climate of the university is favorable.

This is not to say, however, that success along these lines is limited to the university schools. As an example, the procedure followed by one hospital school may be pertinent: What all those involved in the educational program thought and what they did and are doing about the program and its objectives can be traced in the minutes of meetings of the faculty, the student organization, the school advisory committee, and the board of trustees. This work was begun because the accrediting board which received the school's application for temporary accreditation in 1952 made the following statement among others:

The philosophy and purposes of the school are not clear; they appear limited

in the scope necessary to help students to meet the nursing needs of patients in our society; they are not educationally oriented; there is little evidence that they are used as guides for program planning; they have not led to the development of more specific objectives for the curriculum.

The statement thus criticized read as follows:

> The school aims to give good service to patients; through this students develop skills and interest in nursing as well as personal satisfaction.

This had been formulated by a former director of nursing. Strange as it may seem, the faculty had never studied the statement although about half of its members were fairly well prepared. Neither students nor others concerned with the school had given it any thought. There were no curriculum objectives. From reports contemporary with this statement it appeared that the main emphasis in teaching was to give information and provide the practice of procedures with little relationship between the two. The main emphasis for the learner was on memorization and drill. Examination scores were passing, but the students' behavior with patients was largely directed toward getting things done for them and to them with dispatch and skill. One comment on student performance reports appeared rather frequently, "Student is not interested in nursing, too anxious to get off duty." From this it can be concluded that some students at least were not developing interest in nursing and gaining personal satisfaction from it.

The associate director for education, with the approval of the director of nursing, the hospital administrator, and the board of trustees, helped the faculty, which included both full-time teachers and instructor-supervisors, to become organized into a study group. A resource person in group dynamics was paid by the hospital to help the group to be productive during meetings. Schedules were arranged so that one-half day each week was set aside for meetings. Initial discussion centred, not around objectives, but around what was good and what was poor about the care students were giving, what their attitudes were, and what might be the causes of their behavior. In other words, an attempt was made to identify whether changes were occurring in the behavior of students through education, what these changes were, and if they were desirable from a social and professional point of view.

A bibliography of references for required study by the faculty was accepted. It included references from general education, the social sciences, and nursing education. The group recognized the need for deliberation and the need for action. At intervals the following statements representing consensus emerged. Some of them are direct quotes and some are paraphrases from literature.

1. The ideas we hold about life and education as a part of life represent our philosophy which strongly influences what we strive for — our objectives.

2. Our objectives influence and should guide what we do and how we go about doing it.

3. In formulating and evaluating our statement of objectives, the criteria stated by Tyler[10] shall be used:

   a. Objectives should be formulated and serve as a guide for appraising and improving the program.

   b. Objectives shall be stated clearly.

   c. Objectives should have significance for work and living for the learner.

   d. Objectives should be realistic and attainable for a program of this type and length.

4. The understanding and support, financial and otherwise, of the hospital board, advisory committee, doctors, and nursing service personnel are needed if proposed changes are to be made.

5. It is especially important that everyone *accept the student primarily as a learner rather than as a worker.* We recognize that while she learns she will give service which is of value, but it is a by-product of learning.

6. The primary purpose of education is to bring about desirable change in the behavior of students.

7. Objectives will emerge one by one and will need frequent revision.

8. Curriculum objectives will be thought about as each objective is formulated. They will help the student to understand more specifically the behavior she is to achieve.

9. Changes in the curriculum shall be thought through as each set of objectives is formulated; we should consider con-

tent, method, sequence, and also if we are prepared to teach what we think should be taught. Not all parts of the curriculum may need to be changed.

10. The students will be asked to study and discuss each objective in a separate group and with the faculty.

The group has implemented these statements, some more effectively than others. The statement of philosophy and purposes in 1955 reads:

> We believe each individual student enters the school with individual adjustments to make; that through education she can be helped to adjust happily to new situations, to become self-directing, and to understand and accept her responsibility to society as a citizen and professional nurse.
>
> Therefore, the school aims to prepare qualified young men and women to function effectively as professional members of the health team giving skilled and intelligent care including health teaching to the sick in homes and hospitals.

Some of the content of the curriculum is changed. Some has been added, some deleted, some put in different sequence. Teaching methods have changed. There is less lecture, more use of conference, greater effort to correlate theory and practice. Students spend less time in formal classrooms and more in conferences in patient areas. There is more emphasis for the learner on problem solving.

A few remarks from the diaries kept by students give a clue that the objectives have meaning for them.

> Miss X gave me some additional references which really helped me to understand what to do about Mr. Jones. Miss X knows I'm slow but always manage to "get there" eventually.
>
> The class has voted to volunteer to assist with the drive for funds for the Heart Association. I'm glad we worked out a plan for interpreting this problem correctly and objectively to those we approach.
>
> I think I really understand the importance of being able to communicate by word and body posture now. Teaching Mrs. T. about her salt-free diet when she understands nothing but Turkish has really been a challenge, but I feel good about it. We've used pictures, diagrams, demonstrations. For two days she has selected the right foods. She's very intelligent and charming in any language.

Other schools are making similar progress in the statement and use of objectives. Schools working together in the Councils of Member Agencies of NLN are helping. During the past year or two, schools enrolled in the council have been studying and validating the work of committees which are formulating more definite criteria for different categories of schools.[4] Included in the work of these committees is an attempt to define the behavior that would represent the minimum acceptable for the graduate of the diploma program and to differentiate it from that of the graduate of the collegiate program. Studies are being made by nurse educators. The work of Kakosh and Kreuter, for example, is directed toward identifying behavior that might be considered characteristic of the fully professional nurse. Mrs. Kreuter suggests that there are elements of professionalism in the care given by all types of nursing personnel, but that all schools cannot aim to prepare students with the full range of professional behavior. These ideas could help hospital schools as well as collegiate schools to determine the limits of their objectives.[2]

Needless to say, there are barriers to progress in the development and use of objectives and to concurrent improvement in nursing education. If one reads the Weir Report,[11] the articles in *The Canadian Nurse*, such as "The Evolution of Nursing Education[3]," and American publications dealing with similar subjects, it seems reasonable to conclude that these barriers are common to both countries in varying degrees. Reports on both sides of the border dealing with the shortage of leaders in nursing who are prepared to make an analytical and scholarly attack on the barriers may account in large measure for their persistence. However, individuals and groups inside and outside the profession have identified the following as some of the barriers.

Those who are responsible for and control schools of nursing, those who teach in them, and those who are in nursing service do not always apply to these schools the same concepts of a school and, especially a professional school, as they would to other school. They accept the fact that other schools

are established to serve the needs of the learner and recognize that the learner needs time to achieve the objectives. Florence Nightingale said in speaking of schools of nursing, "There shall be an organization which, in giving proper help, gives probationers time to do their work as pupils;," that is, the school is organized to serve the students.

This is not always the case. How can the student assigned six or seven patients to be washed, fed, dressed, irrigated, medicated, ambulated, recreated, find time to do her work as a student which includes purposeful thinking, feeling, and acting?

If the school of nursing is really a professional school, then it assumes the great responsibility of giving its students time and opportunity not only to recognize but also to understand and accept the obligations to society which are incumbent on the professions.

Some hospital schools have shown a tendency to become fixed in a pattern without regard for the original purpose which governed this pattern. The same subject matter is repeated in the same way year after year. Students nurse diseases and conditions — cholecystectomies, coronaries, depressions — not patients, each one of whom is different and has different needs. Students are assigned to night duty in the first year because it is supposed to be maturing. Is that really the reason for this practice or is it because that is the easiest way of solving a nursing service problem? Aren't nursing service and nursing education each of enough importance to warrant the best solution rather than the easiest one? Isn't the safety of our patients important enough to have them cared for by nurses who have had time to develop judgment through knowledge and experience? When we do these things do we really believe that we will help to develop creative nurses? Will these students be bored automatons or will they more nearly resemble the students in the second class noted above?

Finally, the actual job of identifying and stating the educational objectives for students and developing a program through which these may be achieved is usually given to the specialists in nursing education. However, it seems important for others to be concerned with them. Interest and appropriate assistance is needed from those who control the school, from nursing service personnel, from allied professions so that nursing educators will not be out of touch with reality and off the track. It seems important for these groups to understand the objectives and program if they are to be expected to support them. Indirectly, the objectives of our schools are of most importance to our patient who has a right to nursing care by nurses who can meet not only the challenges of today but also those that will emerge in the future.

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The Bifocal Approach

ADELAIDE SINCLAIR, M.A., LL.D.

YOU HAVE THE ADVANTAGE of belonging to a profession which has long been accepted as both suitable and respectable for women. In this you have the advantage over certain other groups into which women have literally had to force their way and in which they have been both unwelcome and suspect.

I am sure that when you are addressed by someone outside your own profession they never fail to refer to Florence Nightingale. In order not to disappoint you I looked at a recent volume of her life and letters and I shall always be glad that I had occasion to do so. It is a fascinating account of an extraordinarily able woman whose interests ranged far beyond her work in the Crimean War with which she is usually associated. Her pen was both vigorous and uninhibited. There were two comments I could not resist which show the progress which your profession has made in one century.

> No man, not even a doctor, ever gives any other definition of what a nurse should be than this "devoted and obedient." This definition would do just as well for a porter and it might even do for a horse.
>
> There is a commonly received idea that it requires nothing but a disappointment in love or incapacity in other things to turn a woman into a good nurse.

Just in case you should be feeling complacent about your professional status, I shall give you one other excerpt that I came across recently in an account of a program to set up rural health centres in Iraq. In order to provide the personnel for the centres a one year's training program was organized in Bagdad but it was found necessary to describe those taking the course as "trainee social workers." They could not be called nurses because "that is a profession still considered as being on the level of domestic service."

Tonight, I want to use what I heard described recently as a *bifocal approach*. Much of your time at this convention must properly be spent in looking through the lower half of your mental spectacles at your immediate professional problems. I hope you will now raise your eyes and look through the upper half at wider and more distant horizons and consider some of the needs which confront nations today. An exercise of this kind in addition to giving you a wider view may also help your perspective when you go back to the lower half of your bifocals.

In selecting certain needs to bring to your attention, while I have tried to choose those that might be of interest to you, I have made a broad selection on the basis of needs that concern all mature and responsible citizens.

The needs of a nation vary depending on its stage of development. I shall first deal with those nations that are known in the international vocabulary as "underdeveloped."

These represent, unfortunately, a very large proportion of the world's people. Because isolation and indifference are no longer possible it is important that we should be aware of their problems. Most of them are fac-

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Mrs. Sinclair, who is executive assistant to the Deputy Minister of National Welfare, Department of National Health and Welfare, presented this address during the 28th Biennial Convention.

ing a vicious circle of disease, ignorance and poverty which they are striving to break. In many of these countries life expectancy is less than 30 years. Compare this with the Canadian figure in the high 60's.

A year or two ago my Department had a visit from the Minister of Health for India, Rajkumari Amrit Kaur. She is a most fascinating woman. In describing the health problems of her country she said, with justifiable pride, that within recent years the life expectancy in India had been raised from 26 to 30 years. When you consider that the population of India is between three and four hundred million you will realize that this is no mean feat.

Another index is the infant mortality rate. Compare Sweden's which is 20, with 200 which is not uncommon in underdeveloped countries. In some local areas it is believed to run as high as 300 or 400. Consider the ratio of nurses to the population. In Canada, we have 1 to 286, in the Phillipines there is 1 to 5400 and in India, there is 1 to 55,000.

Many of these countries are subject to ravages of diseases, such as malaria, tuberculosis, yaws and trachoma, that take their toll in death and disability every year. Impure water supply and poor sanitation lead to many gastro-intestinal diseases. Malnutrition is another serious problem, whether it results from insufficient food or ignorance of how to use existing food supplies.

It is estimated that at least half of the world's population is illiterate. One result of this is the great lack of trained personnel in all fields. This is often more serious than a lack of funds because unless there are people available who can properly utilize supplies and equipment these are of little use. The staff shortage in the health field is so great that many mothers are attended by no one except untrained village midwives.

There are, however, two encouraging factors in what could admittedly be a very gloomy picture. One of these is that the apathy and resignation which used to be characteristic of many of these countries are disappearing. There is an increasing desire among these people to raise their own standards and an awareness that this is possible. The second is that international assistance of various kinds is available to help them in their efforts. I should like to give you a few illustrations of how this is being utilized. The World Health Organization and the United Nations Children's Fund have many joint projects in the health field. The Children's Fund uses its resources to provide supplies and equipment while the World Health Organization supplies the technical advice and personnel. This latter, of course, includes a large number of nurses.

New drugs make it possible to conduct mass campaigns against some of the more prevalent diseases at a minimum cost. For example, in the field of prevention, BCG vaccine has been used against tuberculosis. It is safe to say that the work in the last eight years probably represents the largest mass health campaign ever undertaken in the world's history. Over 160,000,000 children have been given tuberculin tests. Those with a negative reaction, somewhere about 50 per cent have been vaccinated with BCG. It is not possible to estimate how many children have been spared tuberculosis by this means but the numbers must be very substantial.

Top priority is being given to campaigns to eradicate malaria. Spraying at the appropriate time of year with DDT has destroyed the mosquitoes and reduced the incidence of malaria. The spraying did not require a high degree of skill so it was possible to conduct this campaign with a minimum of expense. A great improvement was brought about in many of the most serious malarial areas in the world. In recent years, investigation has proved that the mosquitoes were not without resources and that they were developing a resistance to the DDT. If this continues there was reason to fear that the whole problem might flare up again. The only answer seemed to be the complete eradication of the disease before the mosquitoes' resistance to DDT became established. This has meant a much more intensive and complicated campaign because the work had to be carried into every village where there was even a trace of malaria, for any residual pocket

of infection could re-infect the whole community. It is, of course, possible that man will prove to be no less resourceful than the mosquito and may invent a new insecticide against which resistance will not be built up. Until this occurs top priority is being given to assisting countries with eradication campaigns.

While it is sound therapy to promote prevention, there are also campaigns that attempt to cure existing diseases. One of the most horrible infections of tropical areas is yaws which infects whole villages with terrible sores that cripple rather than kill the juvenile population. For centuries it was assumed that nothing could be done about this but with the advent of penicillin it was discovered that most cases of yaws could be cured with a single shot — only the more obstinate ones requiring two or three. This made it feasible, financially, to undertake an active campaign. It required the cooperation of the whole community to be sure that all the cases were mustered when the visiting team arrived. First, the head man of the village had to be persuaded. In one part of Indonesia, the children were induced to come because they were invited to a party at which an old Tarzan film was shown. There was no admission fee but no child was allowed to see the film until he had been examined and, where necessary, had had his shot of penicillin. Many countries can definitely look forward to the prospect of eliminating yaws within 5 or 10 years.

Trachoma, if not treated, frequently leads to blindness. At the moment there is no easy one-shot treatment. When requests for assistance were received there was a fear that it would be impossible to organize successful campaigns which required several treatments a day over a period of months. Here again the experiment has succeeded far beyond what had been hoped. By enlisting the aid of school teachers, who agreed to supervise the programs, tremendous improvement has been made in areas such as Taiwan and North Africa where the experiments have been undertaken. Children are being trained to persuade the older members of their family to have treatment at home.

As these mass campaigns developed in various countries it became obvious that there is a real need to build up the basic health services in the rural areas where about 80 per cent of the population live. International aid is also being channelled to assist in this development. In this field, many Canadian nurses have played a very important part.

One of the basic principles in all these international programs is that the aid is given to assist countries in developing their *own* services and is only given at their request. The receiving countries have, therefore, the responsibility of making the plan and undertaking the local organization through which foreign supplies and personnel are channelled. It is understood that when the initial period of assistance is over the countries themselves will continue the work with their own funds and their own personnel as part of their regular health services. There is now ample evidence that the countries that have been aided are both able and willing to continue the programs.

In all of these developments for which assistance is sought there is need for more than skill and efficiency. These problems must be approached with imagination, with sympathy, with flexibility and with respect for the existing cultural patterns. When one is asking a people to change a way of life that has prevailed for centuries it is nothing short of a revolution. Many of these new techniques and remedies come with a sudden impact that we in the western countries, where they have come gradually, have never known.

Where women are in "purdah" as in many of the Muslim countries, it takes courage to emerge into the world of everyday affairs. In Afghanistan, women in seclusion may not be treated by a male doctor, yet in the whole country a few years ago there were only two women doctors — foreigners — and they were in the capital, Kabul. In certain parts of Asia no woman may be treated by a doctor who is younger than her husband. Whatever we may feel about these customs the fact remains that they are a very real part of the society in which they prevail and cannot be lightly set aside.

We do not yet know what this sudden impact of modern techniques on comparatively primitive society is going to do to that society but it is bound to have profound effects. It will need great understanding on our part to help with the transition.

When we come to the so-called developed countries the picture changes. Many of the more obvious needs have been met, many diseases have been eliminated or are under control. We have sanitation, we have pure water supplies, we have a reasonable supply of food and in most cases we have free public education. Industrialization has raised our standard of living but it has brought with it new problems. One of these is large urban concentrations of population which brings new health problems and creates shortages of housing. In this latter field we still have a long way to go and perhaps have lessons to learn from other countries.

Bombay has an interesting law on housing. They recognized that as large industries attempted to establish themselves in the city they would undoubtedly attract large numbers of people from the rural areas to work in their plants. As housing was already acute, a law was passed requiring any new industry that wished to locate in Bombay to provide housing for the number of people they wished to employ before they began operations. This was a very sensible way of profiting by the mistakes that have been made in western industrial countries.

The stresses and strains of an industrial society and its tempo have brought their own toll of mental illness. Since improvement in health has brought greater longevity, we are confronted with many problems of the aging population which are nonexistent in less developed countries. I recall a very interesting conversation that I had with a visitor from Pakistan who confessed himself as frankly shocked at our treatment of old people. He explained that in his society it would be considered a disgrace if the older members of the family were looked after by the community, that this was a family responsibility which should be assumed with both pride and pleasure. He thought it indicated a degree of materialism in our society that we expected the state to provide pensions, medical care, housing and other facilities for old people. While I agreed that we have developed a considerable degree of materialism in our society, I tried to explain that there might be circumstances which made this pattern both more understandable and more justifiable than he felt it was. To begin with, because of our longer life expectancy the problem of old people has reached greater proportions in Canada than it has in Pakistan. It is not uncommon here for a family to have four grandparents living. Housing facilities, particularly in urban areas, no longer permit the inclusion of all the older members of the family. The greater mobility of our population means that families frequently are scattered and unable to provide personal care and shelter for parents and grandparents.

Family responsibility provides no solution for numbers of old people who are completely alone without any close relatives. As a result of the size and nature of the problem we have now reached a stage where we accept the fact that the community as a whole has a responsibilty for these people. This might be regarded as an extension of the family conscience to the state. Perhaps it is not a backward but a forward step.

The last need to which I want to refer, is one of which we are becoming increasingly aware — the necessity of recognizing that man is a whole person. Because of our increasing knowledge and resources our society has tended to produce specialists in narrower and narrower spheres. In addition to many new professions which have developed in the past 50 years, we have tended to establish rigid categories within professions. We have to face the fact that this has created a number of vested interests, a fair amount of professional jealousy and a tendency to make mysteries of the particular tasks that we perform. This has reached a point where we have been compelled to recognize that these water-tight compartments are not always beneficial to the people that the professions are supposedly trying to serve. A whole person has a variety of needs — health, nutrition, shelter, education, recreation, employment, spiritual and mental satis-

faction. To be of help in one area, it may be very important to have a knowledge of needs and resources in other areas and to secure the assistance of the experts in those fields. More and more we are becoming aware of the value of teamwork for which we have invented a high-sounding phrase — the multi-disciplined approach. This need for teamwork is perhaps a good one on which to end.

There are, of course, many needs that only nurses can meet but there are also many ways in which you can, if you have the will, fit into the larger pattern of the helping professions. The plea which I would make is that you do not neglect, from time to time, to look through the upper half of your bifocals to the larger needs of the world so that you, with many others, may justify the faith that Arnold Toynbee has expressed when he said that "'the Twentieth Century will be chiefly remembered not as the age of political conflicts or technical inventions, but as an age in which human society dared to think of the welfare of the whole human race as a practical objective."

K. P. for Double-Duty Homemakers

LOUISE PRICE BELL

MANY HOMEMAKERS OF TODAY run a home and hold down a nursing job as well. Doing both things well is a challenge, but the duties can be made to dovetail in an efficient manner if the planning is sound. System is important in homemaking. When homemaking and career are combined, system is something to be really considered!

Allow time enough in the morning for a nourishing breakfast eaten in an unhurried manner, if you want to start the day right for both bread-winners. To assure a pleasant homecoming at night either wash the dishes, stack them neatly, or pack them in the dishwasher. This will take very little time and means less work at night. If possible, make the beds, too, as coming home to an orderly house does much for that late-afternoon slump.

Most working couples get their lunches away from home, so breakfast and dinner are the main considerations. Your day off can be "marketing day," and the time to stock up on the things you will need during the week. Store staples in a cupboard, vegetables and fruits in the refrigerator, frozen foods in the home freezer. Knowing that you're "set" for a week gives a feeling of satisfaction. You can whip up a dessert or two, a gelatin salad, and perhaps a casserole for baking early in the week. If you like to cook, you can even concoct things to store in the freezer against the unexpected arrival of an old nursing pal.

Tastes vary; people have different likes, allergies, and peeves regarding food. As the homemaker, you should work out the menus or stock meals that you know from experience are satisfactory. Having a few of these on tap, or having the ingredients to make them, will mean that you can quickly prepare and serve them. Good springboards for any meal are easily-prepared foods that you have done over and over so that there is little chance of failure. Suppose, for example, your chili wins applause every time you serve it . . . With greens in the refrigerator, Melba Toast and crisp crackers in the cupboard, and frozen broccoli in the freezer, you can serve fresh fruit for dessert and feel that the meal is a well-balanced one that is sure to please.

A rib-sticking dinner that men like is roast pork, baked in a nest of sauerkrout, with potatoes getting done to a turn with the same heat. All you need with this is a green vegetable and a salad, with perhaps a tomato juice starter and a fruit and cookie finish.

Baked beans and brown bread are hearty, and flanked by cabbage salad with sour cream dressing, raw carrots,

Mrs. Bell resides in Tucson, Arizona.

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Hydrocephalus

JOANNA JENKINSON

SOCIAL BACKGROUND

Little Vickie, an 8-month-old, 22 pound baby girl was admitted to hospital in May, 1955 and placed under observation for hydrocephalus. She was the second of two children, the first of which — a 3-year-old-girl — was normal in all respects.

MEDICAL BACKGROUND

Vickie was born in September, 1954, after a somewhat difficult labor. Her weight at birth was seven pounds. Her mother stated that neither she nor the attending physician considered the baby's head to be unusually large at the time of delivery. Previous to admission, the baby had taken her feedings well, and had gained weight normally. There had been no unusual vomiting or fretfulness but there was a tendency to constipation. Past medical history revealed only the occasional cold which was insignificant in making a diagnosis. The principal concern had been the rapid enlargement of Vickie's head.

GROWTH AND DEVELOPMENT

In the field of growth and development, Vickie's progress had been close to normal being hindered mostly by her heavy, immobile head. A child of eight months should be sitting alone, creeping on all fours and beginning to pull herself up alongside furniture. Because of her heavy head Vickie was confined to a supine position.

Her dentition was almost normal. Her four central incisors — two upper and two lower — were in place and the left lateral upper incisor was also present. The only deviation from normal here was the absence of one upper lateral incisor normally present in 8-month-old infants.

A baby of this age is, as a rule, drinking from a cup. Vickie was unable to do this but took pureed foods and cereal well by spoon.

PHYSICAL EXAMINATION

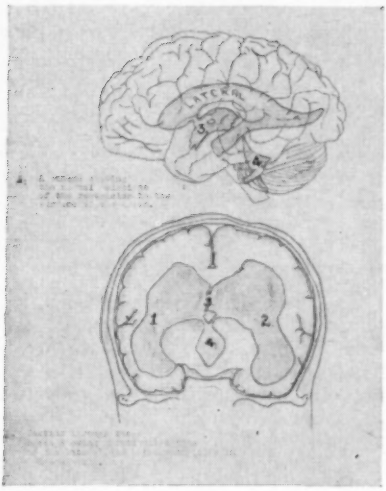
The general physical examination showed nothing unusual except the very obvious abnormality — the greatly enlarged head. The child's head was 52½ cm. at its greatest circumference and 35 cm. from ear to ear. The enlargement of the head was in its uppermost portion and the cranial sutures could easily be palpated. The fontanel was tense. The forehead was bulbous and the eyes protruded in the manner characteristic of hydrocephalus. Neurological examination was negative. Vickie moved all extremities well, appeared to be alert, and behaved in a fairly normal manner except that she was unable to move her head freely. A provisional diagnosis of hydrocephalus was made pending further investigation.

HYDROCEPHALUS

Briefly, this is a condition in which the amount of cerebrospinal fluid is increased greatly above normal. It results in an increased size of the head and characteristic pressure changes in the brain.

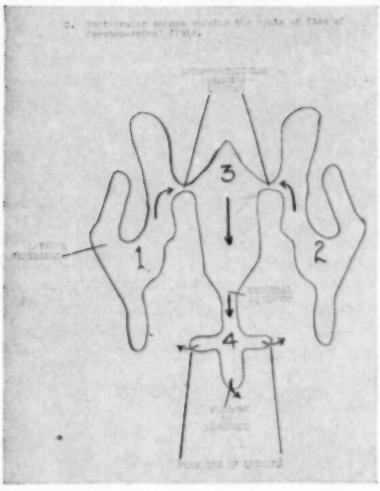
Normally there is a delicate balance between the rate of formation and of absorption of the cerebrospinal fluid. The entire volume is absorbed and replaced once every 12 to 24 hours. The fluid is secreted primarily by the choroid plexuses in the lateral, third and fourth ventricles of the brain. As far as can be determined, there is limited secretion from any other source. The choroid plexuses are highly vascular folds or processes of the pia mater in the ventricles. From the lateral ventricles, the fluid flows through the foramina of Monro, the third ventricle, thence through the aqueduct to the fourth ventricle. Here it escapes through the roof of the foramina into the cisterna magna and

Miss Jenkinson was a second year student at St. Joseph's Hospital, Victoria when she carried out this study.



A. A scheme showing the normal relations of the ventricles to the surface of the brain.

B. Section through the brain showing marked dilatation of the lateral and third ventricles in Hydrocephalus.



C. Ventricular scheme showing the route of flow of cerebrospinal fluid from the lateral ventricles (1, 2), through the third ventricle (3) (foramina of Monro), the aqueduct, and the fourth ventricle, from where it escapes through the foramen of Magendie.

then up the basilar cistern beneath the pons through the opening in the tentorium into the subarachnoid spaces. From there it passes around the cerebral hemispheres to the arachnoid villi of the sagittal sinus. Although there are other areas of absorption present the process is accomplished chiefly through these villi. For all practical purposes, unless there is adequate absorption into the sagittal sinus, the balance between the secretion and absorption of fluid will be altered and a state of accumulated cerebrospinal fluid or hydrocephalus will develop. The problem of the surgical treatment of hydrocephalus begins with the study of the secretion and absorption of this fluid.

Classification

Obstructive Hydrocephalus: This classification implies that there is an obstruction or block to the normal flow of spinal fluid somewhere in the ventricular system. It produces an accumulation of fluid within the system and increased pressure with dilation of the ventricles themselves. Possible causes may be congenital or acquired abnormalities.

Communicating Hydrocephalus: This is a state in which there is a free flow of cerebrospinal fluid within the ventricular system to the subarachnoid pathways over the spinal cord and surface of the brain. The defect in normal cerebrospinal fluid physiology in this condition is one of reabsorption. The disturbance in absorption — the most common cause of hydrocephalus — may be classified as follows:

A. Those of *congenital origin:*

Failure of the foramina to become patent.

Disturbances in the development of the aqueduct.

B. Those of *infectious origin:*

Congenital infections, toxoplasmosis, etc.

Meningitis, either acute or chronic, with secondary fibrosis and obliteration of the cisterna or subarachnoid channels.

Chronic arachnoiditis of unknown origin.

C. Those of *vascular origin:*

A cerebral hemorrhage at birth may block some of the channels. The reabsorption of the blood may be associated with fibrosis which may lead to permanent obstruction to the flow of cerebrospinal fluid.

D. Those of *neoplastic origin:*

In general, hydrocephalus is more likely to occur where the tumors are adjacent to some of the foramina.

E. Those of *unknown origin:*

This is a group with a communicating type of hydrocephalus in which no specific pathology has been demonstrated. Various causes such as fetal meningitis have been suggested but none have been proven.

Signs and Symptoms

In many cases of congenital hydrocephalus the child dies in utero. At other times the process may be so far advanced before birth that Caesarean section or craniotomy may be necessary before delivery is possible. In perhaps the majority of cases, no symptoms — as in Vickie's case — are apparent at birth or the head is only slightly larger than normal. The signs and symptoms of the condition are usually manifest when the child is two or three months old. Vickie presented a typical picture.

The first noticeable sign of the condition often is that the head is increasing in size at an abnormal rate. Instead of the customary half an inch a month, it may be two or three times this. If the progress is rapid, other symptoms are soon evident. The infant cannot hold up his head; he is lethargic; all his perceptions are dulled. Only in rare cases is there blindness but there is usually some interference with vision. This is difficult to check in small infants. The pupils are equal, though they may be dilated. Nystagmus and convergent strabismus are often present. In severe cases the great weight of fluid distorts the roof of the orbit by pressure from above, pushing the eyes downward and causing them to protrude slightly, so that some of the sclera is visible above the cornea. Due to tightness of the scalp the upper eyelids are pulled up. This further exposes the cornea and gives the characteristic expression associated with exophthalmus. Optic atrophy of greater or less extent accompanies severe cases. Very rarely is there deafness. There is usually rigidity of the muscles of the extremities.

For a time nutrition is well maintained but when the head enlarges markedly the body wastes. The disproportion between the two may seem more marked than it really is. Convulsions sometimes occur. Cases which develop early and progress rapidly are usually fatal before the end of the first year and frequently before six months. The usual termination is from nutritional failure frequently associated with infection and anorexia. Cranial bedsores develop sooner or later. In some instances this may lead to pressure necrosis of the skull and a terminal meningitis. Intelligence is usually impeded. The veins of the scalp become distended due to the drainage of intracranial circulation through emissary veins into the peripheral circulation.

All these symptoms were markedly noticeable in little Vickie. It was very depressing to nurse her as her condition progressed rapidly.

Laboratory Tests

When Vickie was admitted to hospital, the usual routine urinalysis was done. This proved normal in all respects. Routine hematology indicated a normal blood picture.

Wassermann and colloidal gold tests done on the cerebrospinal fluid were negative. The Wassermann test was done to determine the presence of congenital syphilis. The colloidal gold test is specific for increased protein which would be indicative of meningeal infection.

X-Ray Reports

Reports from the first x-rays taken of Vickie's skull indicated that there was considerable enlargement of the cranium with marked prominence of the convolutionary impressions which indicated hydrocephalus.

Phenol red was injected into the right lateral ventricle and within a half-hour a lumbar puncture was done. The cerebrospinal fluid obtained was distinctly colored. This was a good indication that the type of hydrocephalus being dealt with was communicative and the problem faced was one of reabsorption.

Vickie Goes To Surgery

In June, Vickie made her first trip

to the operating room. In preparation for this both sides of her scalp were shaved the morning of the operation. Her blood was grouped and cross-matched.

Preoperative sedation consisted of morphine gr. 1/200 and scopolamine gr. 1/300 one hour before operation, and 10 cc. of 2% sodium pentothal by rectum twenty minutes previously.

Morphine — depresses the sensory and psychic areas of the cerebrum thereby quieting the patient and making anesthetic induction easier. Respirations should be checked as morphine depresses the respiratory centre in the medulla giving slower and shallower respirations. The heat regulating centre is also depressed and diaphoresis may be present. The patient should be kept warm and free from draughts.

Scopolamine — decreases the secretion of saliva and mucus in the nose, pharynx and bronchi, thus leaving the mouth and air passages dry. This reduces the hazard of aspiration. It also favors the absorption of the inhaled anesthetic agent.

Sodium Pentothal — a rectal injection of 2% sodium pentothal was given for further sedation. This made the child more manageable and reduced the amount of inhaled anesthesia required. Later, in the operating room, the only anesthesic needed was an additional 4 cc. of sodium pentothal by rectum.

The operative procedure was a ventriculogram, which is a process of injecting air into the cerebral ventricles. It was used to determine the degree of dilation of the ventricles. A lumbar puncture needle was inserted into each lateral angle of the anterior fontanel. Clear ventricular fluid issued under increased pressure from each needle. Stilets were withdrawn and oxygen was introduced into the ventricular system as the cerebrospinal fluid ran out. In all, 400 cc. of oxygen were injected. At the close of the injection a few minutes were allowed to elapse so that the intracranial pressure was just about the same as, or a little less than it had been, at the beginning of the procedure. The needles were withdrawn and the patient removed to the x-ray department for films.

X-ray reports showed the entire ventricular system to be grossly dilated. This dilation was most marked in the anterior horns. As a result, the cerebral tissue was becoming compressed into a thin shell lining the cranium. The air passed readily through the ventricular passages to the cisterna magna and pons, but failed to infiltrate the remainder of the subarachnoid space. These findings indicated a communicating hydrocephalus, presumably of congenital origin.

Nursing Care

Now that the diagnosis of hydrocephalus was confirmed, Vickie's nursing care became a challenge. As is usually the case with hydrocephalics, Vickie was a feeding problem. She vomited approximately every second feeding during the first part of her confinement in hospital although there had been no evidence of this while she was at home. She also appeared to have some trouble suckling. The maintenance of her nutritional status was most important with the pending major surgery. It was found that she had less trouble in keeping down solid foods, such as pablum and pureed fruits and vegetables, than she had with her formula. In spite of this feeding problem, Vickie did not lose weight.

The second major problem faced in nursing little Vickie, and which is present in the nursing care of every case of hydrocephalus, was the prevention of pressure sores on her heavy immobile head. Her head had reached a size where she could not hold it up nor could she assume a sitting position without her head being supported for her. It had to be moved for her frequently to prevent pressure sores. The scalp was given particular attention in so far as cleansing and general care were concerned. A foam rubber pillow was used as a preventive measure. It is well to remember that unless the head becomes too enormously heavy, holding the child for feedings will relieve pressure for short periods.

Both before admission and during her entire period of hospitalization Vickie had a tendency towards constipation. This was corrected with glycerin suppositories.

Again Vickie was booked for surgery. This was to consist of a right nephrectomy, a laminectomy, and an arachno-ureterostomy.

Preoperative Care

Because the kidney was to be removed an excretory urogram was done. This was necessary to ensure that the urinary system was functioning properly and that the remaining kidney would be able to carry on. Seven cc. of diodrast (a radiopaque dye) diluted with sterile water and hyalonuridase (for faster absorption) were injected subcutaneously for this examination. The urinary tracts were fairly well visualized on both sides. The structure and function appeared normal; no calculi were evident; the bladder was regular in outline. X-ray films taken of the lumbar and sacral vertebrae showed no osseous abnormalities.

Nothing was given by mouth the morning of operation. At 8:00 a.m. a cut-down was performed into the great saphenous vein in Vickie's right ankle for parenteral administration of fluids. A metal cannula was inserted and an intravenous of normal saline was begun.

One hour preoperatively morphine gr. 1/120 and scopolamine gr. 1/300 were administered hypodermically. Twenty minutes preoperatively, 12 cc. of sodium pentothal were administered rectally. Vickie was taken to the operating room where induction was accomplished with nitrous oxide and cyclopropane.

Nitrous Oxide — may be given as a prolonged anesthetic if the gas is used with the necessary amount of oxygen. It is, however, a respiratory depressant and cyanosis must be watched for. Untoward effects on the kidneys, liver, circulation and respirations usually come from oxygen deficiency. It is most frequently used as an induction anesthetic.

Cyclopropane — a colorless gas, is administered by inhalation. It is explosive but has a wide margin of safety and oxygen can be given with it. It affords a greater muscular relaxation than nitrous oxide but causes more postanesthetic nausea. Respiratory depression may come on very rapidly. Danger signals such as slowing of the heart and arrythmia must be watched for.

At operation a laminectomy was performed in the prescribed location. After the laminectomy was completed the dura was seen to bulge. At this point Vickie was turned on her left side, and the right kidney was exposed and removed. The ureter at the ureteropelvic junction was sectioned. A multiperforated polyethylene tube was threaded about 4 cm. down the ureter.

An incision was made in the dura mater and arachnoid mater through which a considerable amount of cerebrospinal fluid was evacuated. The polyethylene tube which had been previously led into the site through the wall of the laminectomy incision, was cut long enough to allow a small loop to be formed. The end of the tube was prepared with additional lateral perforations and was introduced into the subarachnoid space for a distance of 5 cm. Here it was securely fastened and the dura mater was pulled tightly around it at the point of entry. The laminectomy incision was closed in routine fashion. Before Vickie left the operating room, 1.5 cc. of phenolsulphonthalein dye was injected into the right lateral ventricle.

In the operating room, 100 cc. of the normal saline which had been attached to the cut-down was absorbed. This was followed by 100 cc. of 5% glucose in distilled water. Subsequently, 200 cc. of whole blood were administered and finally 300 cc. of normal saline were given. This was necessary to prevent a drop in blood pressure and shock. It also combatted dehydration and protected against carbohydrate depletion.

Postoperative Nursing Care

On Vickie's return to the ward from the recovery room, her color was good and she was apparently in satisfactory condition. The development of the numerous early signs and symptoms of the various postoperative complications were watched for — especially those of hemorrhage. There is always a remote danger of the ligature about the renal pedicle becoming loosened causing internal hemorrhage, following nephrectomy.

Leg restraints were applied to keep the cannula being employed in the cut-down in place in the vein. It was most important that this be kept in good working order. Vickie refused everything offered by mouth and

dehydration during her first few post-operative days was prevented by parenteral therapy. Vickie was kept warm. Her position was changed frequently to prevent hypostatic pneumonia. Dressings were checked frequently for oozing from operative sites. Temperature, pulse and respirations were observed closely.

Achromycin 25 mg. was administered intramuscularly twice daily as a prophylactic measure and aspirin gr. 5 was given q.4 h. for pain. It was important to remember that Vickie could not tell us when she was having pain. To prevent any that might occur, the aspirin had to be given on schedule. Neither could negligence be afforded in the administration of the achromycin as Vickie's meninges had been open thus affording an easy portal of entry for infection.

An order was left to save urine specimens and to record the time of collection of each. This was in order to estimate the amount of cerebrospinal fluid which was being excreted via the arachno-ureterostomy. It was for this purpose that the phenolsulphonthalein dye had been injected into the right ventricle following operation. Several urine specimens, sent to the laboratory for P.S.P. content, gave a negative response. This meant that somewhere along the way from the subarachnoid space to the ureter there was an obstruction to the flow of cerebrospinal fluid.

Vickie was scheduled for a revision and re-exploration of the arachno-ureterostomy. The operative incisions made previously were reopened and the cause of the obstruction was immediately apparent. The polyethylene tubing had developed an acute angulation at one point although it had been so directed that there was no acute curve at the time of the previous operation. A second piece of reinforced polyethylene tubing of the same size was substituted.

Urine specimens were again kept and sent to the laboratory for determination of the amount of cerebrospinal fluid being eliminated with the urine. Reports from the laboratory showed that a total of 8% of the P.S.P. dye had been excreted. This was a good sign that the operation had been successful.

The cut-down was kept open with solutions of glucose and saline until July at which time it was felt that Vickie was taking fluids well enough by mouth to prevent dehydration. Her formula was fed to her by spoon, as she still appeared to have trouble suckling. It was important to realize that dehydration could also be caused by depletion of the body's supply of salt. As it was evident that a good share of this was being lost in the cerebrospinal fluid which was being excreted in the urine, sodium chloride gr. 15½ was ordered, to be given twice daily with pablum. Vickie's diet was rapidly increased to include meat purees. Tri-vi-sol drops (a vitamin preparation containing vitamins A,B, C in a non-alcoholic solution) were also ordered as a dietary supplement.

Vickie's head appeared to become smaller and bony prominences from overlapping sutures were almost conspicuous, especially those of the coronal suture.

Parent Education

There was essentially no patient teaching directly involved in this instance. The problem of caring for the child with hydrocephalus in the home was of major concern to the parents. This would involve the same techniques employed in treating the child medically in hospital. Basically, pressure sores had to be prevented and the patient kept as comfortable as possible. Also the parents must be prepared to realize that the child is seriously in need of affection, even more so than the normal child.

Conclusion

The case study of Baby Vickie, though pathetic, produced a valuable learning experience. The fact that it was the first case of hydrocephalus that I had observed, made it more interesting than it would have been for an experienced person. I feel I may, in future, be able to recognize and care more intelligently for any other similar conditions I may encounter.

No evil deed live on. — *The Palindrome*

Scarlatine plus Endomyocardite

HÉLÈNE PAYER

HISTOIRE DE FAMILLE

Fillette de six ans d'une famille de trois enfants dont deux frères, Carole est blonde, a les yeux vifs et est dotée d'un caractère quelque peu masculin. Elle a une prédilection pour les jeux durs et rudes, elle admire ses deux frères et s'efforce inconsciemment de les imiter. Son papa tient une place importante dans sa vie, ses propos nous le prouvent souvent. Sa maman lui est chère aussi, cependant, la tendresse maternelle est quelquefois amoindrie en face des gâteries du papa; réactions psychologiques normales d'une fillette de cet âge. Au cours de sa maladie, on la comble de jouets, ces derniers sont réduits rapidement en pièces. Les plus jolies poupées ne sont pas épargnées, l'instinct maternel n'est pas développé. Carole est brusque et masculine.

Depuis son enfance, peu de maladies contagieuses à noter sauf la rougeole et un impétigo bulleux qui n'a cessé de récidiver; aujourd'hui, c'est une scarlatine contractée dès son entrée à l'école. Mentionnons toutefois qu'elle reçut les vaccins D.C.T. et variole au préalable.

ANALYSES

Hémogramme: dans le but d'obtenir un rapport détaillé de la formule sanguine avec ses modifications dans l'état pathologique présent.

1er rapport: Diminution du nombre des globules rouges et augmentation de la formule leucocytaire.

2e rapport: Diminution moins marquée du nombre des globules rouges et formule leucocytaire moins élevée.

Hémoculture: cette analyse permettant de vérifier la nature de l'agent pathogène est fait à cinq reprises différentes toujours avec un résultat négatif, c'est-à-dire absence de bactéries pathogènes.

Préparée par Mlle Payer, troisième année, Hôtel-Dieu de Montréal.

Prélèvements:

1. Secrétions du nez et de la gorge sur Loeffler.

Rapport: absence de bacilles diphtériques.

2. Secrétions de la gorge sur gélose-sang.

Rapport: présence de streptocoque hémolytique.

3. Ulcérations des joues pour frottis de Vincent et culture sur anaérobie.

Rapport: absence des organismes de l'angine de Vincent; sur anaérobie, absence de poussée bactérienne.

Ces cultures furent faites dans le but de découvrir les agents microbiènes en cause et de permettre l'emploi d'un antibiotique de choix.

Analyses d'urine:

(P.D.) à deux reprises, vue l'importance de suivre l'état du rein au cours de la scarlatine.

Un premier rapport est légèrement modifié tandis que le deuxième est sensiblement normal.

Analyses du sang:

1. *Prothrombine:* révèle 64% au début et 87% par la suite. Cette analyse a pour but de déterminer le taux de prothrombine dans le sang, lequel se maintient normalement entre 80-100%.

2. *Hématocrite:* 27%, alors que l'hématocrite normale, c'est-à-dire le volume des globules par rapport au sang total est de 40-47%.

3. *Sédimentation:* 26 mm. Ce test a pour but de connaître la vitesse de chute des globules rouges. Dans certaines conditions pathologiques cette vitesse de chute est augmentée. La normale: 0.15 mm./hre.

TRAITEMENTS

Sérum glucose 10%, 500 cc. I.V. les deux premiers jours. Sérum béclysyl 500 cc. I.V. le 3e jour et pour 6 autres jours consécutifs.

Ces solutés enrichis de vitamines C (200 mgm.) et B_1 (100 mgm.) compensent à l'insuffisance du régime oral. De plus ces solutés contiennent un antibiotique soit:

Erythromycine 500 mgm. les six premiers jours; soit encore:

Achromycine 500 mgm. le 7e jour.

Aux doses de vitamines mentionnées plus haut et administrées par voie intra-veineuse on ajoute de la vitamine B et K en injection et en capsules.

D'autres antibiotiques tels que: Wycillin, Chloromycine, Achromycine-Elixir et Bicillin L.A. furent administrés successivement, à dose massive au début afin de maîtriser l'infection, ensuite les doses furent espacées au fur et à mesure que la maladie regressait. En outre, l'enfant reçut:

Distreptin nasal puis Neo-Cortef en gouttes nasales.

Auralgan dans son oreille droite.

Neosporin sur lésions d'impétigo de la main droite.

Neo-Cortef opthalmique au début de sa maladie.

Le repos absolu: prescription de non moins d'importance.

Diète: Lacto-végétarienne pour les 20 premiers jours généreuse par la suite.

En dépit de son jeune âge et de la thérapeutique élaborée dans la présente maladie, la petite Carole coopère d'une façon admirable. Tous les médicaments et solutés sont assimilés sans mauvaise réaction et de jour en jour la maladie regresse. La compétence des médecins jointe à la surveillance minutieuse de l'infirmière acheminent très tôt la fillette vers la guérison.

Soins donnés

Le début de la maladie est insidieux et demande un dévouement professionnel de tous les instants et un nursing compétent. La température très élevée a une répercussion sur l'état mental de l'enfant; ici, on recourt avec succès aux lavements à l'aspirine et aux vessies de glace. La fillette fait preuve d'une certaine force morale et durant les jours critiques, elle ne refuse jamais un traitement, sérum ou injection et accepte de bon gré une diète légère. Son tempérament un peu masculin la rend dure à son corps et à certains moments, il faut lui imposer le repos avec rigueur. D'autre part, son caractère enjoué et son besoin d'activité font appel aux principes de psychologie enfantine. L'enfant n'est pas désagréable à soigner comme le sont ordinairement les enfants gâtés ou capricieux. Les infirmières s'attachent vite à elle et suivent avec joie l'évolution heureuse de sa maladie.

Evolution de la maladie

Symptômes à l'arrivée de la malade: Asthénie marquée, toux et angine. Eruption scarlatiniforme, nausées, vomissements alimentaires. Température élevée, cet état fébrile se maintient à 104° et 105° dans les heures qui suivent son admission, parfois du délire et apparition d'épistaxis et de chéilites hémorragiques.

A l'examen: La fillette présente une otite moyenne bilatérale, un coryza purulent, une ulcération à la face interne des joues, une langue sèche, déshydratée, framboisiforme et desquamante, des amygdales hypertrophiées et purulentes, une adénite sous-maxillaire, un rash scarlatiniforme et plis.

Pouls: 148, Température 104°, T.A. 118/60.

Coeur: bruit régulier, claquement du deuxième bruit mitral, bruit assourdi.

Le lendemain, à la visite des médecins ceux-ci constatent que les antibiotiques ont bien agi, mais son état demeure toxique. Les signes d'endocardite persistent.

Au bout de quelques jours, le coryza diminue, le facies est moins intoxiqué, l'état général s'améliore beaucoup et une desquamation abondante apparait.

Après dix jours d'hospitalisation, les signes généraux sont en regression et la desquamation suit son cours. Les bruits du coeur donnent assourdissement du 1er et claquement du 2e foyer mitral. La température baisse graduellement. On considère son état satisfaisant vers le 15e jour. La complication d'endomyocardite est stationnaire, mais la maladie est contrôlée.

Au départ, un souffle systolique très léger persiste mais en prévenant les parents de traiter l'enfant avec ménagements tout rentrera dans l'ordre et la petite pourra poursuivre son année scolaire.

Soins hygiéniques

S'agissant dans ce cas, d'une ma-

ladie *contagieuse*, la technique de *brossage* est rigoureusement observée. L'enfant dans son état fébrile fait de l'incontinence jour et nuit, ce qui nécessite une surveillance étroite du siège. En plus de la scarlatine, elle est atteinte d'impétigo au niveau des joues, endroits de prédilection pour le grattage. Il faut la corriger tôt pour éviter l'envahissement de la peau. La patience unie à un peu de fermeté met fin à cette mauvaise habitude. Les soins aseptiques d'usage et une propreté particulière évident à l'enfant d'autres complications. Sa santé récupérée, l'enfant retourne à ses parents après un mois d'hospitalisation.

Avant son départ, tenant compte que la patiente vit dans un milieu de contagion depuis son entrée à l'hôpital, une technique de départ s'impose. C'est ainsi qu'une *grande toilette*, très minutieuse permet à la fillette de reprendre contact avec l'extérieur sans danger de transporter des germes. Ses parents viennent la cueillir comme une rose encore frêle, ils l'entourent d'une affection chaude et bienfaisante et ne taisent pas leur joie de retrouver leur fille unique avec une santé recouvrée. De son côté, l'enfant est un peu gauche à manifester sa joie, elle s'agrippe instinctivement au cou de son papa, quitte avec une grosse larme sur la joue, la "ma tante" infirmière qui pendant un long mois n'a cessé de veiller sur elle.

C'est ainsi que se ferme la page de la présente histoire. Ce 19 octobre marque le jour de départ de la petite Carole. Je la regarde s'éloigner avec des regrets car elle apporte avec elle un peu de moi-même. A la tristesse d'un moment fait place la satisfaction du devoir accompli et le témoignage d'avoir à l'instar des médecins contribué au rétablissement de ma jeune patiente. De plus, j'ai acquis une expérience nouvelle, un enseignement pratique et l'intime conviction que le nursing fécond est invariablement lié au coeur et à l'âme d'une infirmière.

Sélection

Commentaires

Le monde serait probablement encore dans l'âge des ténèbres si nous n'avions pas eu d'archives. L'histoire, la littérature, la musique, la médecine, le nursing, n'existeraient peut-être pas.

Les notes conservées par les premières religieuses hospitalières furent précieuses à Florence Nightingale pour établir la profession sur des bases plus solides. Ces premiers dossiers ainsi que les siens lui ont été utiles pour démontrer au monde que le nursing et la médecine devraient être unis afin de donner aux malades et aux blessés les soins dont ils avaient besoin.

Les rapports sont devenus une habitude dans la vie de l'infirmière professionnelle. Le progrès du patient est noté dans ses menus détails, et le médecin se sert du dossier comme moyen de diagnostic et de traitement. Par la suite ces dossiers servent pour la recherche médicale et ils aident à une connaissance plus précise des symptômes.

Il y a de nombreux exemples qui pourraient servir à faire valoir l'importance des dossiers. Cependant, il y a beaucoup d'endroits, spécialement dans les petits centres, où ils sont souvent incomplets. Il n'y a pas une banque qui tenterait de manier l'argent des gens sans tenir un compte détaillé des moindres transactions. Combien plus important d'avoir des dossiers suffisants quand il s'agit de vies humaines. Ceux-ci sont essentiels pour les bons soins à donner aux patients.

Plusieurs infirmières se rappellent très bien les symptômes constatés chez tel ou tel patient et les signes d'amélioration de la maladie, mais elles sont troublées quand on leur demande des précisions. Les informations conservées dans la mémoire n'aident pas beaucoup le patient, le médecin et l'infirmière.

Il arrive aussi que certaines infirmières commettent l'erreur de passer trop de temps à faire des rapports, soit par la répétition de certains renseignements, ou en les recopiant d'une formule à une autre. Il ne faut pas non plus que la manière de faire vos rapports soit si compliquée, que vous soyez seule à les comprendre.

Il faut connaître le but principal des dossiers qui est de faciliter le soin de chaque patient. Le dossier contient généralement l'histoire de l'état de santé du patient dans

le passé et de sa maladie présente, le rapport de l'examen physique, les rapports du laboratoire, le rapport du médecin interne, les notes périodiques concernant l'amélioration de l'état du malade, la fiche de température, les ordonnances prescrites par le médecin et les notes des infirmières. Quand le patient quitte l'hôpital, le médecin traitant y ajoute au diagnostic provisoire au moins un diagnostic, ou plusieurs selon le cas.

En plus, le dossier aide la mémoire du médecin. Comme la pratique de la médecine est devenue plus technique et que l'on fait des examens et épreuves de toutes sortes, les rapports écrits sont devenus indispensables.

Le dossier sert aussi de moyen de communication entre les diverses personnes qui soignent le patient; le médecin, l'infirmière, l'assistante sociale, la physiothérapiste, etc.

Le dossier est un document important qui peut servir à prouver certains droits légaux et financiers du patient; par exemple, en cas de réclamations pour accidents, aux compagnies d'assurances, et afin d'attribuer un juste compensation aux travailleurs et aux vétérans. Il est important pour la protection du médecin et de l'hôpital en cas de poursuite judiciaire.

Finalement, le dossier a une grande valeur dans le domaine des recherches médicales.

A certaines d'entre-nous, la tenue des dossiers nous parait une perte de temps, à d'autres une tâche ingrate et ennuyeuse, mais nous serons toutes mieux disposées à faire cet effort si nous avons en vue le bien-être du patient ainsi que l'avenir de la médecine et du nursing. — *Nursing Outlook*, Mars, 1956.

K.P. for Double-Duty Homemakers

(Continued from page 884)

celery and olives are all you need. You can add a simple dessert such as lady fingers shrouded in lemon or chocolate sauce. These sauces can be kept on hand in covered jars in your refrigerator.

A salad plate meal might be made up of a fish or chicken salad garnished with small tomato jelly molds, or by tomato-wedges. Serve with hot rolls and peas in lettuce-cups, lightly covered with French dressing. Warm gingerbread or chocolate cake (package mix) with whipped cream would make a good topper-offer, and coffee is taken for granted for any meal.

Be sure to give plenty of thought to the cake, muffin or roll mixes now so carefully and scientifically prepared. You can stir up and serve a real delicacy after you reach home and make no apologies either! Frozen foods that are entirely prepared are a joy to the married nurse who also has to do K. P. duty. They're good to have on hand for those emergencies that occur every so often. You'll find that if you make out lists, shop intelligently, and adhere to the system you set up, you'll manage very well and take care of both your jobs with efficiency.

Eating habits the world over are undergoing drastic change. Western Europe is consuming more fruit, milk and cheese than before the war. Bread is replacing rice in some countries of southeast Asia. Americans are eating less grain products and potatoes and more eggs, green vegetables, citrus fruits and tomatoes. Economic factors play a role in such transitions. At low income levels, people eat mostly cereals, starchy roots and tubers. As their wealth increases they resort more to peas and beans, animal products, other vegetables and fruits.

— *Scope*

In the absence of some compelling complaint, the average man or woman infrequently seeks out his personal physician routinely and at stated intervals for a periodic health appraisal. For one reason or another, the public has not fully accepted this positive approach to preventive medicine as applied to the individual and for which he must pay himself, even though the cost be moderate and reasonable.

— *Medical Times*

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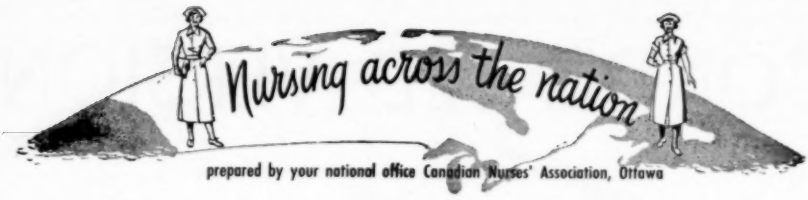

Miracles — Yes or No?

Are the days of miracles over? One wouldn't think so if one could sit in on the Regional Directors' Conference, Victorian Order of Nurses for Canada. Twice a year the national staff of V.O.N. meet at their national headquarters in Ottawa. The other day in a discussion of rehabilitation and the part the V.O.N. is playing in rehabilitation programs, case histories were reviewed which sounded more like miracles than anything we've heard. Here is the gist of some of the cases discussed:

A man who had worked on a ferry boat for some years was stricken suddenly with a cerebral hemorrhage that paralyzed his right arm and leg. After he was transferred from hospital to his home, the V.O.N. visited daily on request of the family doctor. Following such an active life, his disability concerned him greatly. Gradually, under the guidance of the nurse and with practice and perseverance he was able to flex his leg but not extend it. The joy of accomplishment showed in his face when upon the arrival of the nurse he greeted her with "Look nurse, I can do it."

The next step was to be able to hold a cup to take a drink. This was accomplished by using an empty tin cup, so that if he did drop it there would not be a casualty. Then a little water was put in it, then a porcelain cup was used, and finally he was able to master a glass of water, or a cup of tea. This took weeks of patience, encouragement and every day practice. What person, who through days and weeks of being fed does not hail the day with real joy when he or she can feed herself?

* * *

Mrs. X, a woman in her early forties, was confined in hospital. Within two weeks following her delivery she suffered a cerebral hemorrhage resulting in paralysis of her left arm and leg. Following this she became very depressed as she felt that she would never be able to look after her new baby and other members of her family (two children and husband).

Her situation seemed so hopeless that she had no interest in carrying out the treatment and no desire to see if any improvement could be made in her condition. She was discharged home under the care of the physiotherapist and a housekeeper.

After a period of time the family found that they could not afford to carry on with the treatments. Within six months of the wife's illness the husband was diagnosed as an inoperable cancer patient and died within a short time.

It was then that the wife realized that it was very important for her to take more responsibility for her family. It was suggested that she seek help from the Victorian Order of Nurses.

The Victorian Order nurse visited daily and under the direction of the doctor gave the necessary treatments and exercises. The encouragement that the patient received from the nurses' visits was a great factor in her recovery. Over a period of time improvements were gradually noted.

Today, after three years, the patient is completely responsible without outside help for her own housework. Some assistance is given by her older sons. The Victorian Order of Nurses continue their visits on a spaced basis but these will soon be discontinued as the patient gains complete independence.

* * *

With Canada's population age level increasing, with cardiovascular disease on the increase, and, to be completely mercenary, with the cost of illness increasing, what next to prevention itself could be more important than the part nurses can play in the rehabilitation of our patients? What must be the joy and sense of accomplishment of patients thus helped!

Looks as if he belongs to a family of good cooks

Even the most conscientious young mother finds it difficult to cope with the techniques of modern baby feeding. She lacks time . . . facilities . . . and often access to the best quality foods. It is not always easy, or convenient for her to adhere to a well-balanced diet for the toddler who has graduated from strained food and is not yet ready for adult fare.

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Ideas for Chapter Meetings

Could your National Office help with your chapter meetings? *The Canadian Nurse* has carried articles on accreditation of schools of nursing. Those who attended the biennial meeting in Winnipeg know that the voting delegates there reaffirmed belief in the principle of accreditation of schools of nursing and voted to conduct a pilot study of evaluation of schools of nursing as a possible preliminary to a full accrediting program.

We believe that the first step in any program is the education of ourselves. Accordingly, our thoughts go immediately to the chapter meeting. What better place to discuss this whole topic? In the chapter meeting each member of the C.N.A. can say what she personally thinks of accreditation; or it may be that this whole idea of accreditation of schools of nursing is new to us. Of course we have heard, and perhaps even spoken of accreditation, but what is really involved? What are the techniques of the accrediting program? What staff is required and what is the cost? These are questions we are all asking. So let's talk it over, in meetings, in discussion groups at our chapter meetings. To assist local groups in this endeavor National Office has prepared:

1. A speaker's brochure.
2. Sample questionnaires that might be used at the chapter meeting. Try handing them out as the nurses gather. Ask them to fill them out before the meeting and again following the meeting.
3. Loan folder for those who really want to go "into the depths" of this subject.

If we in National Office can help in the organization of your chapter meetings let us know.

Three Provinces Visited

The fortieth anniversary of the N.B. A.R.N. took place in October. The annual meeting of the Association highlighted nursing education as a result of the research project carried out during the past year in that province. A panel discussion on this topic was presented in which the CNA Nursing Education secretary participated.

In October the R.N.A.O. held a conference on "Improving the Quality of Nursing Care" at Sunnybrook Hospital, Toronto. In the planning period, questionnaires were sent to 1164 agencies and the topic of the conference was chosen from the replies. Our Nursing Service secretary attended as a resource person.

A visit to Newfoundland was recently made by the General Secretary, where she visited St. John's and addressed nurses gathered for the Public Health Convention in that city.

Annual Meeting in Saskatchewan

TWO HUNDRED AND TWENTY-SEVEN members attended the sessions of the 39th convention, S.R.N.A., held in Regina in May. Miss Mary T. Mackenzie, president, chaired all main sessions. Mayor L. H. Hammond and Rev. J. R. Hord participated in the opening ceremony which was televised for the benefit of members unable to attend. Miss V. Antonini expressed the appreciation of the members to the honored guests.

The program for this annual meeting had been planned to provide as much information as possible regarding developments in nursing in Canada and particularly in Saskatchewan. A survey of topics covered serves to indicate that this objective was most adequately attained. "Recent Developments in Saskatchewan's Health Services Program" were comprehensively discussed by Dr. Milton I. Roemer, Director, Medical Hospital Services Branch of the Department of Public Health. A panel chaired by Miss L. Miner, "What is New in Nursing and Emergency Planning?" brought nurses up-to-date in areas where their participation is of immediate concern. As part of this topic Mr. C. P. Johnston, provincial director of Civil Defence, discussed "Developments in Civil Defence Health Services Planning"; Miss Hazel Keeler described the National League for Nursing Test

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Pool Examinations and their use in the province; Miss Mary Mackenzie presented current developments in Canadian nursing and Miss Lola Wilson reported on developments in the centralized teaching program and the work of the Kellogg Foundation. Further stimulus was supplied in the addresses given by Miss M. Pearl Stiver, General Secretary, and Miss Leonora Collatz, Executive-Secretary of the Minnesota Board of Nursing and assistant to the Division of Nursing Education of the National League for Nursing. "National Accreditation — a Forward Step in Nursing" was the timely subject of the address by Miss Collatz.

Mrs. June Orr chaired the student session when the guest speaker was Dr. H. O. Dillenberg, medical bacteriologist of the Provincial laboratory. Dr. Dillenberg spoke on "Bacterial Cross-Infections in Medical Institutions and Their Prevention."

Highlights of the work undertaken and accomplished by the provincial association included the establishment of a pension plan for provincial office staff; the development of the new "Recommendations Relating to Personnel Policies for Nurses"; activities in relation to tuberculosis and psychiatric affiliations for nursing students, financial aid for students, bursaries for graduate study; civil defence as it related to nursing. A new fee schedule for private nurses was accepted by the general session. At their special meeting, the public health nurses welcomed Dr. A. C. Kanaar, Medical Director, Physical Restoration Division as the guest speaker. His subject was "The Nurse's Role in Rehabilitation." "The Rh Factor and Hemolytic Diseases of the Newborn" were reviewed by Dr. O. E. Laxdal in his address during the Institutional Nursing session.

Reports were presented from the various provincial committees telling the story of a busy year. The treasurer's report indicated a satisfactory financial picture for the new executive. Members elected to office included: Mary T. Mackenzie, pres.; L. Willis, L. McColl, vice-pres.; Committees: E. James, nursing education; V. Antonini, nursing service; Mrs. C. O'Shaughnessy, publicity; L. Long, chapters. In 1957, the annual meeting will be held in Saskatoon, May 16-17.

LOLA WILSON
Executive-Secretary
Treasurer
Saskatchewan Registered
Nurses' Association

Le Nursing à travers le pays

Quelques suggestions concernant les assemblées de districts.

Votre secrétariat national peut-il vous aider dans vos assemblées de districts ou de chapitres? Le revue L'Infirmière Canadienne a publié des articles sur l'accréditation des écoles d'infirmières. Celles d'entre vous qui ont assisté au congrès de Winnipeg savent que les déléguées se sont prononcées une fois de plus en faveur du principe de l'accréditation des écoles d'infirmières et d'une étude sur l'évaluation des écoles en vue de préparer le programme d'accréditation. Nous estimons que le premier pas à faire dans l'organisation de tout programme est de nous renseigner nous-mêmes. Notre pensée s'est donc immédiatement reportée au district et à ses réunions; y a-t-il une meilleure occasion pour discuter de cette question? Dans les assemblées de districts, chaque membre peut dire ce qu'il pense de l'accréditation; il se peut bien que la question ne nous soit pas encore très familière. Bien sûr, nous avons entendu parler de l'accréditation et même nous en avons un peu discuté mais, en réalité, de quoi s'agit-il réellement? Quelles sont les techniques d'un programme d'accréditation? Quel personnel cela requiert-il? Quel en est le coût? Voilà autant de questions que nous nous posons. Alors, parlons-en dans nos assemblées, discutons de ce sujet en groupe. Afin d'aider les associations locales, le secrétariat national a préparé:

1) Une brochure à l'usage du conférencier.

2) Des questionnaires pouvant servir dans les assemblées et que l'on distribuera aux infirmières lors de ces réunions. Demandons-leur d'y répondre avant l'assemblée et de nouveau après l'assemblée.

3) Un dossier contenant une certaine documentation pouvant être prêté à celles qui désirent étudier la question plus à fond.

Si nous pouvons vous être utiles dans l'organisation de vos assemblées, faites-le nous savoir.

Miracles, oui ou non?

Le temps des miracles est-il passé? On

"Meat protein as well retained as milk protein..."

EVEN premature infants digested, utilized and retained the proteins and fat in specially prepared Meats for Babies according to Sisson, Emmel & Filer, "Meat in the Diet of Prematures", Pediatrics, 7, 89 (1951).

The authors state, in part: "Meat protein is as well retained and utilized as milk protein by the premature infant and is therefore as safe and efficient a source of protein as milk. The fat absorption of the premature infant is not significantly altered when the milk in the diet is partly or wholly replaced by meat fat or meat fat and olive oil."

Swift's Meats for Babies was the original product of this kind placed on the market. Prepared from only fine, lean meat, the food is cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.

7R1-56

Meats for Babies

SWIFT'S

most precious product

Swift

To Serve Your Family Better

SWIFT CANADIAN CO., LIMITED.

ne le croirait pas en écoutant les délibérations des membres du Victorian Order of Nurses sur la réhabilitation. Deux fois par année, ce groupe se réunit; cette année l'on étudia le rôle du V.O.N. dans la réhabilitation; les histoires de cas présentées furent étonnantes et les résultats obtenus semblaient tenir du miracle. En voici quelques exemples.

"Un homme travaillant dans un bateau passeur depuis plusieurs années fut soudain atteint d'hémorragie cérébrale; il resta paralysé du bras et de la jambe gauche. Une fois sorti de l'hôpital, il fut visité tous les jours par une infirmière du V.O.N., à la demande du médecin. Il va sans dire qu'après avoir mené une vie aussi active, son infirmité actuelle l'inquiétait grandement. Graduellement, sous la direction de l'infirmière, avec de la pratique et de la persévérance il devint capable de plier sa jambe mais non de l'étendre; mais un jour, la joie rayonnait sur son visage lorsqu'il vit entrer l'infirmière: "Regardez, dit-il, je puis le faire."

Il s'agissait ensuite de lui faire tenir une tasse et de boire. L'exercice débuta avec une tasse de fer-blanc et vide; le malade pouvait donc l'échapper sans crainte de rien gâcher; puis on y mit un peu d'eau ensuite on se servit d'une tasse de porcelaine et enfin, il vint à pouvoir tenir et boire une tasse de thé ou un verre d'eau sans aucun accident. Cela demanda naturellement des semaines de patience, d'encouragement et des exercices quotidiens. Quelle personne qui après avoir été alimentée comme un bébé durant des jours, des semaines, ne salue pas avec la plus grande joie le jour où elle peut manger seule!

Voici un autre cas remarquable: Madame X, au début de la quarantaine, accoucha à l'hôpital. Deux semaines après elle fut atteinte d'hémorragie cérébrale suivie de paralysie du bras et de la jambe gauche; elle devint très déprimée et crut qu'elle ne pourrait jamais plus prendre soin de sa famille (2 enfants et le père).

Son état semblait désespéré; elle ne témoignait aucun intérêt au traitement ni aucun désir d'améliorer son état; à son départ de l'hôpital pour la maison, elle fut confiée aux soins d'une physiothérapiste et d'une ménagère. Après quelque temps, la famille, faute de ressources, dût cesser les traitements. Six mois après la maladie de son épouse, le mari tomba malade d'un cancer jugé inopérable et mourut peu de temps après.

C'est alors que Madame X. réalisa qu'elle était obligée de prendre la responsabilité de sa famille et quelqu'un lui suggéra de demander le secours du Victorian Order of Nurses.

L'infirmière du V.O.N. la visita quotidiennement et, sous la direction du médecin, lui administra les traitements et lui fit faire les exercices prescrits. L'encouragement que lui apporta l'infirmière fut un facteur important de sa guérison.

Aujourd'hui, après trois ans, Madame X fait tout le travail de la maison avec l'aide de son fils ainé. L'infirmière du V.O.N. la visite encore de temps à autre mais bientôt cela ne sera plus nécessaire.

L'augmentation de la durée moyenne de la vie, l'accroissement des maladies cardio-vasculaires et, si l'on veut être tout à fait matérialiste, avec le coût de la maladie qui augmente sans cesse, qu'y a-t-il de plus important, après la prévention, que la réhabilitation de nos malades? Quelle ne doit pas être la joie de ces personnes que l'on a ainsi secourues!

Visites dans trois provinces

L'Association des Infirmières du Nouveau-Brunswick célébrait en octobre dernier son quarantième anniversaire. A l'assemblée annuelle, le sujet du programme fut: "L'éducation en Nursing" une étude ayant été faite sur cette question au cours de l'année.

En octobre, l'Association des Infirmières d'Ontario tient une conférence sur "L'Amélioration de la qualité des soins infirmiers", à l'Hôpital Sunnybrook de Toronto. Le sujet fut choisi d'après les réponses reçues à la suite de l'envoi de 1164 questionnaires.

Une visite fut faite dernièrement à Terreneuve par la secrétaire générale de l'A.I.C. qui visita St-Jean et adressa la parole aux infirmières réunies dans cette ville.

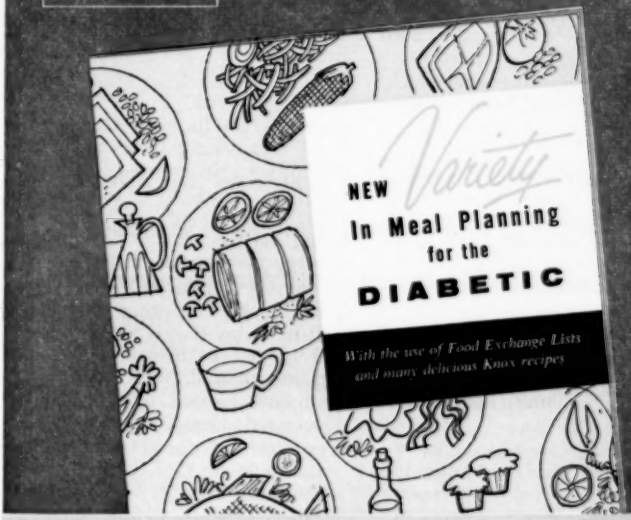
Chez les nôtres

L'éducation du personnel tient actuellement la vedette dans nos institutions. A l'Hôpital Maisonneuve, avant l'entrée des élèves, les infirmières furent invitées à participer à des journées d'études. L'orientation, les relations interpersonnelles, le travail d'équipe, l'interrelation de l'école et du service du nursing, méthodes d'enseignement, furent les sujets au programme.

A l'Université de Montréal, l'Ecole d'Hygiène offre aux infirmières des unités sanitaires un programme intéressant et pratique.

L'Association des Infirmières réunit en congrès les infirmières du service industriel. L'hygiène mentale dans l'industrie fera l'objet d'une étude spéciale.

KNOX Protein Previews



Newest Knox Brochure Aids Dietary Management of Diabetics

The new Knox booklet "New Variety in Meal Planning" has been prepared to help you enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance—Food Exchange Lists[1]—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply for your own use, fill in the coupon below.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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Please send me.....copies of the new Knox diabetic brochure describing the use of Food Exchange Lists.

YOUR NAME AND ADDRESS

The Meaning of Rehabilitation

FRANK G. WELLARD

REHABILITATION HAS BECOME a word to conjure with. Not that it hasn't a right to be used in the many applications in which it is — because there is authority for them — but because it wasn't commonly used in those applications until it came to be widely used with reference to disabled persons.

Here are the definitions that Webster lists, first for "rehabilitate," then for "rehabilitation":

Rehabilitate:

1. To invest or clothe again with some right, authority or dignity; to restore to a former capacity; to reinstate; to qualify again; to restore, as a delinquent, to a former right, rank or privilege lost or forfeited; a term primarily of civil and canon law.

2. To restore to good repute by vindicating; to clear of unjust or unfounded charges; to re-establish the good name of.

3. To restore to a former state of solvency, efficiency or the like.

4. To put on a proper basis or into a previous good state again; to restore; to re-establish; specifically, to restore a person, as a disabled soldier, to a status of independent earning power through a course of instruction under state supervision, especially along vocational lines.

Rehabilitation: — The act, process, or result of rehabilitating; the state of being rehabilitated; restoration of a right, one's good name, one's health and efficiency, etc.

Sir Ernest Gower, English author of "The Complete Plain Words," quotes one, Ivor Brown, as saying this about the uses and abuses of the word "rehabilitation":

> The present darling of the departments . . . is rehabilitation, a word originally applied to the restoration of a degraded man's rank and privileges. By the middle of the 19th century, it was occasionally used to mean restoration of other kinds. Suddenly it has become the administrator's pet. A year or two ago, nothing was mended, renewed or restored. Everything had to be reconditioned. Now reconditioning has been supplemented by rehabilitation, which has the merit of being one syllable longer. The blessed word "goes" officially with everything from houses to invalids . . .

The word leaps at us from all sides. There is the Civilian Rehabilitation Branch in the Department of Labor. There is the Maritime Marshlands Rehabilitation Act. There is the Prairie Farm Rehabilitation Act. Closer home, there is a strong move to rehabilitate the ailing coal mining industry; and when the wind blows too hard in the fall, the apple industry needs rehabilitating. Last year, shortly before the era of ferry transportation to Cape Breton closed forever, one of the ferries burned in its dock. The press carried the report next day that it would be refloated and moved to a neighboring marine slip for rehabilitation. And a special fund was created to "rehabilitate the devastated homes" in the Liverpool area after the forest fires last year.

It would be nice, from our point of view, if the word "rehabilitation" could be used just to define what we are interested in — certain services for disabled people.

What, then, should we accept as our definition of rehabilitation? The most used one is that of the International Labor Organization — "the restoration of the disabled to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Going back to Webster for a moment, our concept is broadened as we accept — "the act, process, or result of rehabilitating" all as rehabilitation. It is not only a process; it is any or all of the elements in that process, and it is the end result of the process.

To go a bit further, there are a number of quotable quotes which help to clarify our thinking about rehabilitation. Most references are to the physically handicapped. We skirt the subject of rehabilitation of the mentally ill, because, although we are aware of the magnitude of the problem, we are less aware of what we can do about it. We consider the mental problems of the physically handicapped, and look for-

Mr. Wellard is Rehabilitation Coordinator for the province of Nova Scotia.

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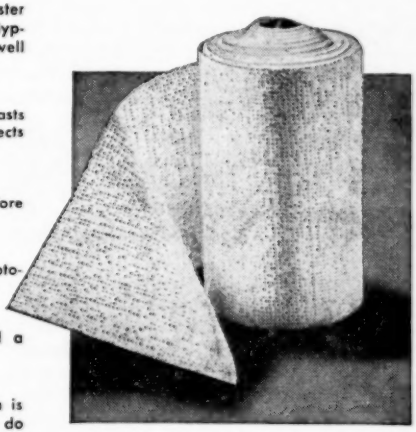

Gypsona Extra is available in the following sizes: 4" and 6" by 3 yards.

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ward to the time when it will be possible to do as much for the mentally ill. It is to be noted, too, that while this paper refers particularly to the physically disabled, all of the principles cited apply with only slight reservation to the conditions of the aged or the chronically ill.

The physically handicapped, then, are those individuals who have a physical defect, obvious or hidden, which limits their capacity to work or evokes an unfavorable social attitude. That bears closer examination. We are inclined to think first of the paraplegic or the amputee, or the person ambulant with braces and canes or crutches when we think of the disabled. But what of the cardiac, the tuberculous, the diabetic, to name only a few who may be even more disabled than the more obvious are, and are more handicapped because their disabilities are hidden and therefore do not evoke for them a sympathetic and understanding consideration of their condition? And what of the people whose disabilities do not prevent them from working, but do incite fear or repugnance in those with whom they are to work and live? The ex-tuberculous still often face this handicap. We know the annoyance and frustration with which we, whole people, often face association with the deaf mute or with the drooling and grimacing cerebral palsied. There are other examples of disabilities which evoke an unfavorable social attitude.

For these and the many other kinds of disabled persons, rehabilitation has come to be regarded as "the process, the creative process, in which the remaining physical and mental capacities of the physically handicapped are utilized and developed to their highest efficiency." It is an organized and systematic method by which the physical, mental and vocational powers of the individual are improved to the point where he can compete with equal opportunity with the so-called non-handicapped.

"The so-called non-handicapped" is well said. If proper recognition is given to areas of competence which exist or may be developed, handicaps become less significant. After all, what is important is not what people cannot do because of their disabilities, but what they can do in spite of their disabilities. Today society, business and industry pay for ability to think and for hand skill. Most disabled people can do some useful and gainful work. You don't have to be able to run 100 yards in so many seconds to be a great leader. The average individual uses only one-third of this physical ability in doing a day's work.

We come, then, to a consideration of the various elements that make up rehabilitation. Broadly speaking there are three. They are: *medical rehabilitation, vocational rehabilitation,* and *job placement.* Involved in these basic elements are many special skills. The areas in which these skills operate will overlap in many places. Therefore it is most important that each specialist recognize the areas in which he or she can and should serve. At the same time, each specialist should have some knowledge of and appreciation of the role of all the other specialists. Out of this approach comes the concept of the team.

Because disability is involved, the whole rehabilitation plan for an individual revolves around his medical condition. The doctor is the key person on the team. Medical attention is necessary as soon as possible after the disability is incurred or recognized, so that the greatest degree of physical restoration is possible. When this has been achieved, medical supervision of any further rehabilitation process is needed to ensure that there is no aggravation or recurrence of the disabling condition.

The doctor has certain allies as he goes about the business of getting his patient back to as nearly normal as possible. These allies are the nurse, the physiotherapist, the occupational therapist, the speech therapist, the remedial gymnast, the prosthetist. All may not be needed for each case; but all are there, ready to bring their skills to bear when needed.

Ready to interpret the effects of disability to patient and family, if necessary, is the social worker with special skill in handling emotional problems and personal adjustments.

The purpose in restoring the disabled person to the best possible physical condition is twofold. It is to make him as comfortable as possible, and it is to make him as fit as possible to

INTRAMUSCULAR

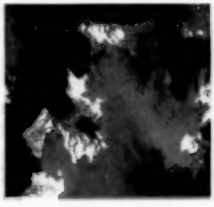
VARIDASE*

Streptokinase-Streptodornase Lederle

provides remarkable control over inflammation

Physicians now find that patients with inflammatory lesions respond dramatically when VARIDASE is given intragluteally. Hitherto unattainable areas may be treated by VARIDASE Intramuscular.

When employed in this manner, VARIDASE lyses the "limiting membrane" of leukocytes and fibrin which is thrown up about an inflamed or infected area. Thus, liquefaction and resorption of the contained exudate is made possible. In case infection is present, or feared, the physician may administer an antibiotic such as ACHROMYCIN* Tetracycline at the same time to prevent the development of generalized sepsis.



Recent investigation has extended the list of indications for Intramuscular VARIDASE therapy to include abscesses, burns, cellulitis, edema, epididymitis, hemarthrosis, sinusitis, lymphangitis, lymphadenitis, and thrombophlebitis with or without superimposed infection.

VARIDASE Intramuscular (Water Soluble—No Oil)—Simple mixing instructions are included in the package literature.

Administration: INTRAMUSCULAR, deep in the upper, outer quadrant of the buttock

Lederle

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earn a living and be independent. If it happens to be a housewife who is concerned, it is to make her as fit as possible to carry on her domestic duties. If you don't think that is earning a living, just ask a housewife!

In principle, it is better to rehabilitate a disabled person to the occupation they originally had, if they had one. It has to be recognized, though, that in many cases of severe disability this is not possible. There is comparatively little vocational adjustment involved for the bookkeeper who has recovered from far-advanced tuberculosis or through an accident, is obliged to get about with the help of crutches. If the same person were a seaman or a lineman for a power company, however, a complete change of vocation is necessary. Here new skills come into play. The psychologist or the vocational counsellor helps the disabled to find the interest or skill which they can develop to the greatest advantage. This is not a hit and miss proposition. Standardized tests establish the rehabilitant's intelligence level, and point to the field in which an occupation may be selected. The final selection is made in consultation with the doctor and the employment specialist. There is no point in picking a type of work that is going to be physically harmful. There is little point in selecting a vocation at which a person cannot get a job.

At this point it is quite possible that some preparation for a new vocation will be necessary. A person with a disability can well be benefited by training for a job that will eliminate the handicap imposed by his disability. If he has the educational background and the intelligence to master a new trade, training awaits him either in a school or on the job at which he will work when he becomes skilled. What new horizons have been brought into the view of handicapped people who, only a few years ago were condemned to a life of comparative uselessness! There is literally no limit to the skill that a disabled person may acquire if they have the basic qualifications to start them on a career of usefulness.

Not everybody who becomes disabled is a good training prospect. It is folly to think that everybody who is injured should be made over into a new being who does something entirely different from what he did before. Age, intelligence, education are all factors which determine whether a person having attained their physical optimum, should be placed on the labor market or should be trained. The greatest problems are found with the people who need a skilled job, but have not the mentality nor the education to benefit from training. This is particularly so in provinces where the economy is based on primary industries — fishing, farming, lumbering and mining. A great many people who become disabled in their forties or later, are found to have left school when they were in Grade III or IV. They have worked hard all their lives, and there have been no complications until something happened that prevents them from working hard again. If they cannot be trained, or cannot benefit from training, every effort must be made to find a job into which they can fit with their residual capabilities.

Job placement of the physically handicapped is a special skill in itself. It involves not only matching the physical and mental qualifications of the disabled person who wants employment with the job he can do. The placement specialist must be prepared to go out to look in industry and in the labor market for jobs for his clients. And he must know how to sell his product, because it does have to be sold. Employers do not yet accept the fact that a person with a disability is not necessarily handicapped. There are too many who automatically say, "Sorry we have nothing for you today," meaning that they have nothing for a disabled applicant ever. They say it without giving any thought to the fact that before them is a person who can do some things, the things they are asking for a chance to do, just as well as somebody who has a whole body, but has not the special need and the drive to justify the fact that he is a good bet for the job.

Employment is the end product of rehabilitation, if you like. The man who has become disabled needs more than to be put back together again if he has a family dependent on him. He needs more than to be trained for an occupation. All the work of doctors, nurses, therapists, counsellors, results only in his being more comfortable in his body, but less comfortable in his mind if he cannot put his abilities to work.

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The person who is handling the placement probably has the hardest part of the whole process of rehabilitation to accomplish. This is true because if that person fails in his part of rehabilitation, all the work, the skills and devotion that have been brought to bear by the other members of the team appear to have been for nought.

Since employment is so important, let us examine some of the possibilities more closely. One thing we do have to realize is that, in spite of the best that can be done for some cases medically and vocationally, they are never going to be able to go out and compete in the regular labor field. In some cases they will never again be able to leave their homes. In others they will never be able to work fast enough and steadily enough to be acceptable in a job situation where their rate of production may affect the effectiveness of a whole operation. On the other hand, if a work situation can be created for them, these people can do a lot to help to maintain themselves and can be more satisfied and self-respecting citizens as a result.

A work situation can be created for these people either in sheltered shops or in the home. Homebound and sheltered employment make useful producers of many who cannot compete in speed or cannot get out of their homes. In most cases they develop a business in collecting, repairing and reselling articles of used clothing and household fixtures and furniture. The repairing and reconditioning is done in what is known as a sheltered workshop where work and not speed is the essential.

Many disabled persons are job conditioned in this sort of an environment before moving into the regular labor stream again. Others find employment for the rest of their working days in a place where they are important because they can do *something*, and not because they can do it at such and such a speed. Usually a homebound employment program is associated with a sheltered workshop. Routine jobs of sewing, repairing or assembly or packaging can be done by the people who cannot get away from their homes, provided there is an organization for getting the work

to them and collecting it again.

I may have dwelt at some length on employment's part in rehabilitation. You will recognize, I am sure, the important place it has in the whole process. You will realize that modifications of the employment services for the disabled may be adaptable to the circumstances of the chronically ill, who form a very important part of the disabled.

We have talked about the team approach to rehabilitation and have listed members of the team. But so far we have not mentioned, specifically, the most important member of the team. That is the disabled person who wants to be rehabilitated. He or she is the one who determines whether rehabilitation is going to be successful. Only the disabled can provide the motivation, the courage, the persistence in spite of obstacles. We can provide the services that restore, that train or retrain, but we cannot make the disabled use them. The disabled are not rehabilitated. They rehabilitate themselves.

In Memoriam

Cécile Clermont, infirmière diplomée de l'Hôpital St.-Luc en mai 1933, est décédée subitement le 10 septembre dernier à l'âge de 47 ans. Mlle Clermont a fait longtemps du service privé puis a été présidente du Registre de l'Hôpital St-Luc durant de nombreuses années. En 1953, elle entrait au Laboratoire Provincial comme technicienne en chimie.

* * *

Eileen Eaves, who graduated from the Royal Victoria Hospital, Montreal, in 1939 died on June 21, 1956 in Montreal.

* * *

Audrey Elliott, who graduated from the Winnipeg General Hospital in 1953 died on September 2, 1956, following a brief illness, at the age of 24. Miss Elliott was on the staff of Moose Jaw Union Hospital.

MARGARET HUGHES

* * *

Alice Erskine, who graduated from the Royal Victoria Hospital, Montreal, in 1899 died on July 28, 1956.

* * *

Ruth (Kool) Gaasenbeek died recently at Kingston, Ont. After having received part of her training in Holland, Mrs. Gaasenbeek entered the school of nursing of the Greater Niagara Hospital, Niagara Falls, and graduated in 1955.

* * *

Margaret Hughes, who graduated from The Mack Training School, General Hospital, St. Catharines, Ont., in 1896 died on August 10, 1956, in Portland, Oregon, The founder of the alumnae association of her school in 1901, Miss Hughes maintained close contact with it following her retirement from the public health field in which she spent most of her professional life.

* * *

Sandra Marie Long, who graduated from Holy Cross Hospital, Calgary in 1956 was killed in a highway accident near Ponoka, Alta.

* * *

Laura B. (MacDermid) Lough, who graduated from Lady Stanley Institute, Ottawa, in 1914 died on July 27, 1956. Mrs. Lough served overseas during World War 1.

* * *

Kathleen (Grattan) McLaughlin, a graduate of the General Hospital, Saint John, N.B. died at Montreal on August 15, 1956, following a long illness. Mrs. McLaughlin had worked on the staff of the Moncton Hospital, St. Mary's Hospital,

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Pleasing, spicy taste makes it easy to use.

sparkling red
The mouthwash that tastes good and does good

Montreal and the General Hospital, Medicine Hat, Alta.

* * *

Mary Joyce Roberts, who graduated from the Victoria Hospital, Prince Albert, died suddenly on September 8, 1956 in Trail B.C. Miss Roberts had worked on the staff of Mission Memorial Hospital, Mission City, St. Paul's Hospital, Vancouver, the Vancouver General Hospital, Chilliwack General Hospital and Trail-Tadanac Hospital.

* * *

Mary Francis Stevens, who graduated from The Mack Training School, St. Catharines General Hospital in 1921, died on August 2, 1956. Miss Stevens had engaged in private nursing.

* * *

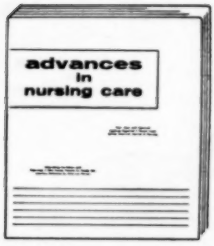
Hilda Muir Stuart, who graduated from Victoria Hospital, London, Ont. died on September 11, 1956. Miss Stuart served with the British Red Cross in Cairo and France during World War 1. She received the Mons Medal, General Service and Victory Medals and the King George V Jubilee Medal. On her return to London she rejoined the staff of Victoria Hospital and became the principal of the school of nursing in 1931. She retired from her profession in 1948.

Authorities at the Oswestry hospital in England have discovered a new medicine for their women patients that works wonders and does not cost a cent — gossip panels to relay to them neighborhood goings-on. Volunteer "gossipers" move through the women's wards, spending 10 to 15 minutes to give each patient the latest birth, death and marriage news. Hospital officials say it does the patients "worlds of good."

The Delphic oracle said that I was the wisest of all the Greeks. It is because that I alone, of all the Greeks, know that I know nothing. — SOCRATES

* * *

The first condition I would give for happiness is to have a sense of values wider than one's own life and personality.
— SIR HUGH WALPOLE



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Book Reviews

From Custodial to Therapeutic Patient Care in Mental Hospitals, by Milton Greenblatt, M.D., Richard Y. York, Ph.D. and Esther Lucile Brown, Ph.D. 484 pages. Russell Sage Foundation, New York. 1955. Price $5.00.

Reviewed by Miss M. Pike, Allan Memorial Institute, Royal Victoria Hospital, Montreal.

In the introduction to this text we find what the authors consider to be the functions of a psychiatric hospital. They are divided and elaborated into the following working hypotheses. That function is:

The utilization of every form of treatment available for restoring patients to health or helping them improve sufficiently to be able to leave the hospital at the earliest possible moment; and, short of such success, it is aiding them to live as nearly normal lives as possible within the institutional setting.

The utilization of *every* form of therapy available requires planned systematic use of the whole environment, consisting both of physical resources and social interaction between all categories of staff and patients.

For purposes of making effective therapeutic use of the social environment of the hospital, including improvement in the motivation of personnel, concepts and methods of research developed by the behavior sciences should be tested and utilized wherever feasible.

The origin, nature and results of the "Russell Sage Project" are next described.

Following this enlightening introduction the book is divided into three distinct parts. Each section reviews the unpleasant background of the past. Gradually we sense the tremendous strides in total environmental change evolving from the combined efforts of everyone: doctors, nurses, attendants, occupational therapists and the patients themselves. In conclusion the authors point hopefully, and possibly wistfully, into a future which embodies the best of all we can offer the mentally ill.

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These achievements were not easily made. The doubts, discussions, worries and fears are effectively illustrated by extracts from notes or quotations. The book ends on an encouraging note, but with a realistic long-term view of the many problems still confronting us. The extensive bibliography is valuable. This book is one that should have a place in every nursing school library.

Thresholds to Professional Nursing Practice, by Frances M. McKenna, R.N., M.A. 347 pages. W. B. Saunders Company, Philadelphia. 1955. Price $4.25.

Reviewed by Miss Gertrude M. Hall, Director of Nursing, Calgary General Hospital, Calgary.

"As indicated by its title, this book is designed primarily to bridge the span of time which extends from an undetermined moment in a student's senior year until she has established herself as an independent professional worker." This, in the words of the author, is the purpose of the course in Professional Adjustments II.

The content and plan of the book represents years of teaching this particular course. Student reaction and comment is noted. The intent has been to place nursing in perspective with other vocations and to incorporate ideals for service and performance.

Unit I contains an excellent chapter on "Thresholds to Adult Living." It appears to be a continuation of the foundations laid in the course given in the first year as Professional Adjustments.

Unit II deals with general considerations leading to employment — seeking, holding and leaving a position.

Unit III discusses opportunities for service in relation to hospitals, schools of nursing, occupational health and various other specialized areas.

Units IV & V are concerned with personal and professional obligations, with the exception of a brief reference to the I.C.N. The professional nursing organizations explained in great detail are those of the United States. Canadian students are quite at a loss to obtain similar information concerning the Canadian counterpart, the Canadian Nurses' Association. One cannot, of course, place the responsibility for this lack on the author or publisher. It is the business of Canadians to prepare their own material for courses in professional adjustments. The book is an excellent reference for teachers and senior students.

Nutrition and Diet Therapy, by Fairfax

T. Proudfit and Corinne H. Robinson. 826 pages. The Macmillan Company of Canada Ltd., 70 Bond Street, Toronto 2, Ontario. 11th Ed. 1955. Price $5.25.

Reviewed by Mrs. Marian Ross, Nutritionist, Department of Health, Parliament Buildings, Toronto, Ont.

This text is designed for the nursing student. The book is divided into five sections covering nutrition in the normal diet and in the therapeutic diet.

Section I, "Normal Nutrition," discusses the relation of food to health, food requirements and normal metabolism of various food constituents. The United States "Recommended Daily Dietary Allowances" and the "Basic Seven" food grouping are given. For Canadian use, it would be necessary to substitute the "Canadian Dietary Standard" and the recommendations of "Canada's Food Rules." There is a practical chapter on meal planning for moderate and low cost meals and an interesting chapter on food patterns of various cultural groups.

Section II, "Normal Nutrition in Special Conditions," deals with dietary planning for pregnancy and lactation, the infant, the preschool and school child and the older person.

Section III, "Diet Therapy," places emphasis on the use of the normal diet as the basis for planning the therapeutic diet. There is a new chapter on nutrition in children's diseases.

Section IV, "Practical Applications of Nutrition," concerns nutritive values, selection, care and preparation of food. A section of recipes follows with many recipes written for individual portions. These are suggested for use in the class laboratory.

The appendix of this text includes a range of tables of food values, average weight for height tables, a health score card, and extensive bibliography and additional references. This well-organized text achieves its stated purposes — to give the reader an appreciation of the role of nutrition in health; to present the fundamental principles of normal and therapeutic nutrition; to encourage the application of these principles to individuals of all age categories.

Errors in Spelling

Everyone has doubts about the spelling of a word and the punctilious have immediate recourse to the dictionary. But there are errors of spelling of which the perpetrators are unconscious and in which they persist, to be thereby condemned. Could it be that nurses are guilty of any such in their correspondence?

After collecting and analyzing 30,000 misspellings by the college students, Dean Thomas C. Pollock of New York University has concluded that comparatively few words are responsible for a large percentage of spelling errors. The Dean enlisted the aid of 599 teachers of English in 52 colleges and universities. He wanted to find the words that college students actually misspell most often in their writing.

The university now has a list of words that give students the most frequent difficulty. The most frequently misspelled word or word-group was "their — they're — there" (440 times). In second and third places were "to—too—two" (434 times) and "receive" (357 times). The other words in the list of the first ten that cause the greatest trouble are (4) exist—existence—existent, (5) occur—occurred—occurring—occurrence, (6) definite—definitely—definition, (7) separate—separation, (8) believe—belief, (9) occasion and (10) lose—losing.

* * *

Why is it that people who are troubled with insomnia are generally so proud of it?

British Columbia

The following is a list of the staff changes which have occurred in the Division of Public Health Nursing, Department of health and Welfare:

Appointments — *Frances Nelson* (Vancouver Gen. Hosp., U.B.C.) to Prince George. *Lucille Leger* (St. Boniface Hosp.) to Cloverdale. *Lois Keating-Fisher* (Saskatoon City Hosp., McGill Univ.) to Courtenay. *Eva Wolf* (Calgary Gen. Hosp., U.B.C.) to Ladysmith, *Ruth Miller* (V.G.H., U.B.C.) to Courtenay. *Frances McAddoo* (Royal Columbian Hosp.) to Terrace. *Nora Larson* (Regina Gen. Hosp.) to Saanich and So. Vancouver Is. H.U. *Mrs. Lydia Boss* (V. G.H., U.B.C.) to Armstrong. *Dorothy Deeble* (St. Paul's Hosp., Vancouver, U.B.C.) to Kamloops. *Mrs. Jessie Bridges* (Univ. Hosp., Edmonton, U.B.C.) to Saanich and So. Vancouver Is. H.U. *Elaine Miller* (Royal Inland Hosp., Kamloops) to Coquitlam. *Nancy Idiens* (Royal Jubilee Hosp., Victoria) to Dawson Creek. *Joan Sutherland* (Toronto East Gen. Hosp., Univ. of Toronto) to Trail. *Mary McCulloch* (Toronto Gen. Hosp., U. of T.) to Abbotsford. *Mrs. Pamela (Dobbin) Weseen* (V.G.H., U.B.C.) to Mission. *Kathleen McArevey* (City Hosp., Belfast, Ireland, Univ. of Hull, Eng.) to Campbell River. *Mrs. Josephine Contini* (Red Cross Hosp., Rome, Rome Univ.) to Saanich and So. Vancouver Is. H.U. *Mrs. Helen Mitton* (V.G.H., U.B.C.) to Kitimat. *Julia Meston* (V.G.H., U.B.C.) to Gibsons P.H. Nursing District. *Elizabeth Murray* (Royal Vic. Hosp., Montreal) to Creston. *Beryl Ross* (V.G.H.) to Kelowna. *Lilie Harder* (V.G. H.) to Salmon Arm. *Joan Lewis* (V.G.H.) to Williams Lake. *Yvonne Morris* (King's College, London, Eng.) to Kamloops. *Shirley Main* is returning from her exchange position in Hull, Eng. to Oliver. *Margaret Brown* (Royal Alex. Hosp., Edmonton) to Oliver. *Mary Stewart* (V.G.H.) to Port Alberni. *Mrs. Myrtle Saxton* (V.G.H.) to Alberni Canal. *Fanny Odell* (R.J.H., Victoria) to Powell River. *Dipo Sardar* (Grace Hospital, Winnipeg) to Prince Rupert. *Chizuko Furuya* (Royal Inland Hosp., Kamloops) to Creston.

Transfers — *Leola Carr* to Campbell River. *Elizabeth Johnson* to Saanich and So. Vancouver Is. *Alice Pement* to Vernon. *Mary Caryll* to Saanich and So. Vancouver Is. *Hazel Fulmore* to Penticton. *Mrs. Frances (Hewgill) Mitchell* to Nelson. *Mary Mc-*

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Leave of Absence — *Merry Andreef, Jean Fleming, Margaret Shepping, Chizuko Furuya, Helen Hawrylak, Ruth Haydon, Julia Hutton Potts, Patricia Todd* have enrolled in the diploma course in public health nursing at U.B.C. *Donalda Ross* has begun postgraduate work at McGill University. *Marion Boyd* is completing advanced study at McGill Univ.

Resignations — *Mrs. Gwen (McKee) Hairsine* from Vernon. *Mary Lange* from Kimberley. *Marjorie Blackburn* who has been on exchange from Hull, England, has returned there. *Bernadine Conroy* from Dawson Creek. *Mrs. Clara Nygren* from the Gibsons Public Health Nursing district. *Mrs. Iva Truscott* from Creston. *Mrs. Beryl Sussel* from Ocean Falls. *Patricia Baillie* from Courtenay. *Mrs. Sybil MacFarlane* from Kamloops. *Mrs. Doris Pearson* from Salmon Arm. *Mrs. Shirley LeBrasseur* from Qualicum. *Mrs. Jessica Field* from Nanaimo. *Marilyn Barber* from Abbotsford. *Doreen Pope* from Smithers. *Solvig Carlson* from Terrace. *Mrs. Evelyn Bockhold* from Coquitlam. *Joyce Davies* from Campbell River. *Gertrude Rach* from Vanderhoof to join the R.C.A.F. *Mrs. Kay Allan* from Saanich and South Vancouver Island H.U. to accept a position as public health nursing coordinator at St. Joseph's Hospital, Victoria. *Jorun Skog* from Oliver to join the Indian Health Services. *Mrs. Betty Carruthers* from Nelson. *Mrs. Willa Stevenson* from Quesnel. *Mrs. Thora McLeod* from Castlegar. *Mrs. Shirley Hill* from Prince George.

* * *

The tuberculosis problem is with us per-

haps to an even greater extent than formerly, because we tend to discharge the patient sooner as chemotherapy controls the contagious aspects more quickly.

— Dr. H. Shubin

* * *

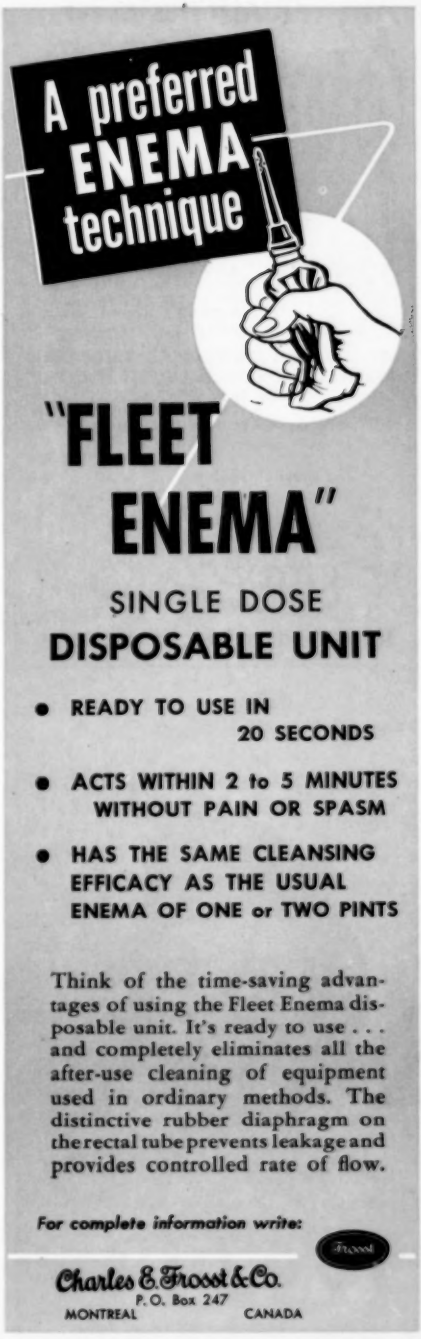
If I have learned anything it is that pity is more intelligent than hatred, that mercy is better even than justice, that if one walks around the world with friendly eyes one makes good friends.

— Philip Gibbs

Ontario

The following is a list of the changes in the Ontario Public Health Services:

Appointments — *Edith Rosenow* (Moncton Gen. Hosp., Univ. of Toronto) to Amherstburg Board of Health. *Helen Herron* (Kingston Gen. Hosp., Queen's Univ.) to Belleville B.H. *Elizabeth (Cooke) Hochner,* (Wellesley Hosp., Toronto, U. of T.), *Barbara MacGregor* (Brantford Gen. Hosp., U. of T.) and *Irma von Allmen* (R.V.H. Montreal, McGill Univ.) to Brant Co. Health Unit. *Marie (Henry) Colling* (Victoria Hosp., London, U. of T.) and *Ruth Thompson* (Wellesley Hosp. U. of T.) to Bruce Co. H.U. *Barbara Bowland* (Toronto Gen. Hosp., Univ. of West. Ont.) to Chatham B.H. *Mary Parish* (T.G.H., U. of T.) and *Vera Slocombe* (Hamilton Gen. Hosp., U. of T.) to Dufferin Co. H.U. *Elizabeth (Williams) Hyland* (Hamilton Gen. Hosp. Univ. of West. Ont.) from Peel Co. H.U., and *Patricia Walker* (R.V.H., Montreal, B.Sc. N. Univ. of West. Ont.) to Elgin-St. Thomas H.U. *Adele Fetterly* (Toronto Western Hosp., U. of T.), *Alice Keryluk* (McKellar Gen. Hosp., Fort William, U. of T.) and *Marilyn Deamude* (Hosp. for Sick Children, B.N.Sc. Queen's Univ.) to Fort William San. *Betty Coney* (Misericordia Gen. Hosp., Winnipeg, U. of T.) and *Elizabeth Law* (Hamilton Gen. Hosp., U. of T.) as staff nurse and supervisor respectively to Galt B.H. *Sarah Ann Lambert* (Hamilton Gen. Hosp., Univ. of West. Ont.) to Haldimand Co. School Health Service). *Esther Matheson* (Oshawa Gen. Hosp., Univ. of West. Ont.) to Halton Co. H. U. *Mavis Barker* (B.Sc. Univ. of Alta.) and *Esther Saisho* (Toronto West. Hosp., U. of T.) to Hamilton Dept. of Health. *Jean Falconer* (Kitchener-Waterloo Hosp., Univ. of West. Ont., U. of T.) as supervisor, *Sara Goertzen* (Toronto East Gen. Hosp., U. of T. and *Glennys Mowat* (R.V.H., Montreal, Univ.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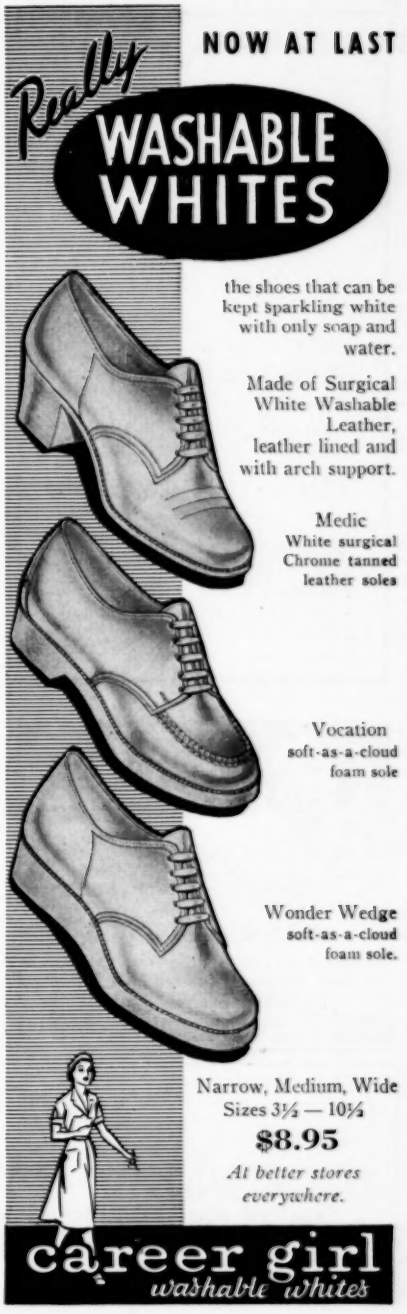
(Hamilton Gen. Hosp., U. of T.) and *Patricia Upshall* (St. Michael's Hosp., Toronto, U. of T.) to Stormont, Dundas and Glengarry H.U. *Marge Grace* (St. Michael's Hosp., U. of T.) to Sudbury B.H. *Marjorie Coristine* (W.C.H., U. of T.), *Susie Janzen* (Greater Niagara Gen. Hosp., Univ. of West. Ont.) and *Yolande Jolicoeur* (Sacred Heart Hosp., Hull, Univ. of Ottawa) to Timiskaming H.U. *Margaret McElheran* (W.C.H., Toronto, U. of T.) as supervisor, Toronto Dept. of P.H. *Mildred McMartin* (McKellar Gen. Hosp., Ft. Wm., Univ. of West. Ont.) to Welland and District H.U. *Betty Miller* (Orillia Soldier's Mem. Hosp., U. of T.), *Christena Miller* (Children's Hosp. of Michigan, U. of T.), and *Margaret Pigden* (Belleville Gen. Hosp., U. of West. Ont.) to Wellington Co. H.U. *Carrie Genik* (Royal Alex. Hosp., Edmonton, U. of T. as supervisor, *Joanne Donald* (T.G.H., U. of T.), *Margaret (McPhail) Harrison* (St. Jos. Hosp., Sudbury, Univ. of Ottawa), *Betty McLaren* (Galt Gen. Hosp., U. of T.), *Nobuko Oikawa* (W.C.H., U. of T.) to Wentworth Co. H.U. *Dorothy (Taylor) Loucks* (Winnipeg Gen. Hosp., U. of T.) to Windsor Dept. of Health. *Cora Lango* (Wellesley Hosp., U. of T.) from St. Catharines-Lincoln H.U. and *Freda (Tomlinson) McKillop* (Sarnia Gen. Hosp., U. of T.) to York Co. H.U. *Mary (Ankcorn) Brunton* (Owen Sound Gen. and Marine Hosp., U. of T.) and *Nora Yeo* (U. of T.) as staff nurse and supervisor respectively of York Township B.H.

Resignations — *Mary Pickens* from Belleville B.H. *Joan Cormack* from Bruce Co. H.U. *Grace (Scott) Shackell* from Dufferin Co. H.U. *Patricia Pietersma* from Elgin-St. Thomas H.U. *Jane Minott* from Haliburton Co. School Health Service. *Mary Petrone* from Fort William and District H.U. *Jean Humphrey* from Kenora-Keewatin-Dryden Area H.U. *Joan Sutherland* from Leeds and Grenville H.U. *Ethel Tingley* from Lennox and Addington H.U. *Maida Harris* and *Audrey Wale* from Northumberland and Durham H.U. *Madalyn (Holmes) Montgomery* from North York Township B.H. *Gaetane Laroque* and *Jean McLaren* from Porcupine H.U. *Fernande Dion* from Prescott and Russell H.U. *Irene Nealon* from St. Catharines-Lincoln H.U. *Patricia (Ball) Kealy, Marguerite (Edwards) Dupuis* and *Dorothy Montgomery* from Stormont, Dundas & Glengarry H.U. *Margaret Anderson* and *Helen Etherington* from Wentworth Co. H.U. *Edith (Munroe) Thompson* from Windsor B.H. *Helen (Elliott) Kennedy* from York Township B.H.



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News Notes

BRITISH COLUMBIA

LADYSMITH

The first chapter meeting of the season was held early in September at the nurses' residence, with an attendance of ten. E. Anderson from Denmark and E. Wolf who recently joined the public health staff of the area were welcomed. K. Bailey, matron of the West Coast Hospital, Port Alberni was the guest speaker at the Vancouver Island District meeting in October.

VANCOUVER

St. Paul's Hospital

The appointment of Winifred E. Taylor to a position on the faculty of the Boston University School of Nursing was recently announced. Miss Taylor did private nursing in Canada for a short time before accepting a position with Beverly Hospital, Beverly, Mass. While there she served first as surgical instructor before becoming nursing arts instructor — a post she retained for five years. In 1955 she obtained her B.Sc. degree in nursing from Boston College. During the past year she has been a teaching fellow at Boston University while completing studies for her master's degree in nursing education. She was one of a group of five who chose rehabilitation as a major area of study.

ONTARIO

DISTRICT 5

TORONTO

Western Hospital

Diplomas were presented to seventy-nine nurses at the graduation exercises of the Atkinson school of nursing in September. The guest speaker for the occasion was Mr.

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W. Harris, Minister of Finance.

G. Sharpe has been appointed chairman of the nursing committee, Ontario Division, Canadian Red Cross Society.

Women's College Hospital

A supper meeting in Burton Hall early in September initiated the season's activities of the alumnae association. A theatre night is to be sponsored later in the season.

Miss Mullen has assumed charge of the operating room. She had previously been with the United Mission Hospital for several years. Miss Simms has returned to the staff following postgraduate study at Columbia University. At this year's graduation ceremony, Doreen Hood received the Mary F. Bowman award for general proficiency.

QUEBEC

MONTREAL

Royal Victoria Hospital

B. Pratt has joined the staff of the Main building as clinical supervisor. M. Vice is a member of the Nursing School Office, Women's Pavilion. S. Osborne is on the staff of the Kirkland and District Hospital, Kirkland Lake. V. Wright is presently with the University of California Medical Centre, San Francisco.

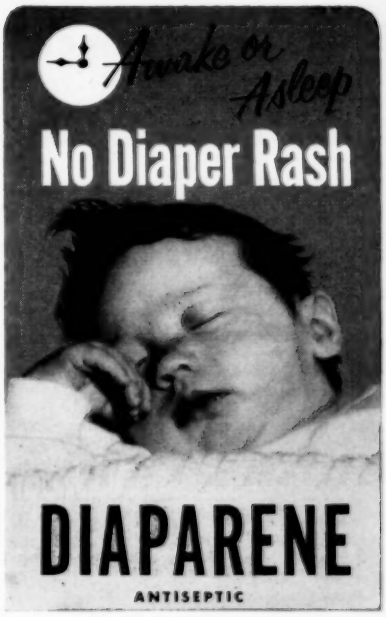
M. Clark, C. Lidstone, D. Arthurs, H. Cilinski and M. Patterson are enrolled in postgraduate study with the School for Graduate Nurses, McGill University. Recent visitors to the hospital have been: A. (Routledge) Draper, L. (McKinnon) Hagberg, M. Baker, A. Muggah and S. Dawson who is presently studying theology at the Toronto Bible College.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

At a gathering of the members of the faculty and the students, 50 young ladies were formally welcomed to the school of nursing in September. The warm welcoming remarks of the chairman, D. Wolfe, were endorsed by the president of the Student Council, G. Peterson, and the president of the Sodality, B. Andreas. The musical program which followed included the traditional class songs. The introduction of the new students by their respective "big sisters" was the main event of the evening. Mrs. Grace Millar, secretary of the Saskatchewan Unit of the Florists Telegraph Delivery Association, presented the annual awards of this association. M. Kammermayer was given the third year student award for the highest standing in theory at the annual graduation exercises earlier this year. F. Aden and R. Ringnose received the second year and first year awards. The singing of the school song and a social hour concluded a pleasant welcoming party.



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Superintendent of Nurses (1). Salary: $275 per mo. **Graduate Nurses (2).** Salary: $235 per mo. less $40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

Graduate Nurse (experienced), capable of assuming position of **Superintendent of Nurses** in new, modern, 25-bed hospital. Required immediately. **Graduate nurses** (2) to complete staff. Salary scale according to R.N.A.B.C. policies. Board & room, $35 per mo. Apply, Administrator, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

Matron (November 1st.) for 27-bed Community Hospital. Salary: $300 per mo. 40-hr. wk. 28 days vacation after 1 yr. service, all statutory holidays paid. Room, board & laundry $40. Good knowledge of X-ray essential. Apply, giving full details to Sec., Slocan Community Hospital, New Denver, B.C.

Superintendent of Nurses for modern 80 bed hospital required immediately. Operating room Supervisor & Registered Nurses for general duty. Good personnel policies and salary for fully qualified nurses. Apply, stating qualifications and experience, to Administrator, Portage Hospital District No. 18, Portage La Prairie, Man.

Superintendent of Nurses for 53-bed hospital. Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: $225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

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Matron for modern 8-bed hospital. Salary: $285 per mo., less $30 for full maintenance. Apply stating experience to Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

Director of Nurses for 250-bed hospital with school of nursing. Suite in nurses' residence, full maintenance. Good personnel policies. Apply, stating salary expected, age, qualifications, training & experience to Administrator, Union Hospital, Moose Jaw, Sask.

Director of Nursing for 185-bed JCAH accredited General Hospital. Protestant Church affiliated. NLN temporary accredited school of nursing, 75 students. Addition to hospital under construction. Must have B.S. degree in nursing & preferably an M.A. in nursing. Good salary, furnished apt., position open early winter. Apply Administrator, Evangelical Deaconess Hospital, 3245 E. Jefferson Ave., Detroit 7, Michigan.

Assistant Director of Nursing, Head Nurse, General Duty Nurses for 150-bed Hospital. 44-hr. wk. 31-days vacation plus statutory holidays, 2-wks. sick leave yearly. Write stating qualifications, salary expected, age & references to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

Night Supervisor. Salary: $2,760-$3,300 plus cost-of-living bonus approximating $325 per annum. Excellent holiday, sick leave and pension benefits. Apply to Baker Memorial Sanatorium, Calgary, Alberta.

Supervisor, starting salary: $225. Must be registered in British Columbia. **Operating Room Nurses,** salary: $230 plus $10 'on call.' $10 postgraduate. **Charge Nurses,** salary: $245. **General Duty Nurses,** salary $230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to $40. 28 days vacation, 10 statutory holidays. 1½ days sick leave, cumulative. Room rent at nurses' residence $20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

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(1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.

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(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

Supervisor of Nursing Service for 50-bed active General Hospital. Salary: $210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainright, Alta.

Supervisor for Pediatrics Dept. with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital, Chilliwack, B.C.

Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

Operating Room Supervisor for 110-bed hospital. Apply, Superintendent, Charlotte County Hospital, St. Stephen, N.B.

Supervisors & Staff Nurses. Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

Night Supervisor, Assistant Head Nurses & Staff Nurses. Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

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Operating Room Supervisor for 118-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

Instructor for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Head Nurses for 340-bed hospital for chronic illness & rehabilitation. Ontario registration & membership in R.N.A.O. required. Gross salary: $250 plus fringe benefits. 3 annual increments. 40-hr. wk. 3 wk. vacation, 8 statutory holidays, cumulative sick leave. Apply Director of Nursing Services, Riverview Hospital, Windsor, Ont.

Registered Nurses or Non-Registered Nurses if recent graduates (4) for very active 50-bed hospital. Salary: $180-$185 depending on experience, plus complete maintenance & laundering of uniforms. $5.00 increase every 6 mo. to a maximum of $200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainright, Alta.

Registered Nurses (2) for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

Registered General Duty Nurse for 18-bed hospital by December 15th. Starting Salary $225 per mo., $5.00 increment every 6 mo. 5 day wk., 10 statutory holidays. Nurses' residence room & board $40 per mo. Apply Matron, Lady Minto Hospital, Ganges, B.C.

Registered Nurses. Single room residence. $225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

Registered Nurses. Gross salary for nurses currently registered in Ont. $235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses. Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

Registered Nurses for General Duty. Initial salary: $200 per mo.; with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

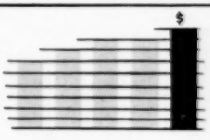
50 Nurses Needed...

HAMILTON, ONTARIO

The three city-owned hospitals, the General, the Mountain with its maternity wing and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.

Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.

Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is $53.00 per week. The daily rate is $10.50 for each eight-hour period of duty.

Hours of duty: (a) 8 hour day—42 hours weekly average —rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.

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Registered General Duty Nurses for 200-bed General Hospital. Salary: $220 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

Registered General Duty Nurse for active 18-bed hospital. Good salary. Vacation with pay, statutory holidays & sick leave allowance. Apply Administrator, District Hospital, Shelburne, Ontario.

Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula. Gross salary: $215, afternoons — $225, nights — $220. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses (2) for modern 8-bed hospital. Salary: $240 per mo., less $30 full maintenance. For further information apply B.E.L. Magnusson, Sec-Treas., Union Hospital, Hodgeville, Saskatchewan.

General Duty Registered or Graduate Nurses (2) for modern 20-bed hospital. Salary: $220 (Graduate), $230 (R.N.). Increment of $5.00 after each 6-mo. service. 1 mo. vacation with pay after 1 yr. service. $30 per mo. maintenance. Separate staff residence. Apply Matron, Riverside Memorial Hospital, Turtleford, Sask.

Registered Nurses for 8-bed hospital. Straight 8-hr. shift. Gross salary: $240-$260 depending on experience. For further information apply Sr. Superior, Notre Dame Hospital, Val Marie, Saskatchewan.

Registered Nurses. Male & Female. Starting salary: $300 up, plus $10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

Registered Nurses for charge duty. Starting salary: $250 per mo., increase of $5.00 every 6 mo. to max. of $275. Evening & night duty $10 per mo. extra. 40-hr. wk. 2 wk. paid vacation after 1 yr. 6 paid holidays. Meals while on duty. Nurses' home completely furnished, including linen & laundry available for $30 per mo. Apply County Memorial Hospital, Gooding, Idaho.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

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General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 430-bed hospital; 40 hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurse for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: $240. Full maintenance $40. 44-hr. wk., vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary. References required. Apply Bulkley Valley District Hospital, Smithers, B.C.

General Duty Nurses (Immediately) for 500-bed hospital. Attractive personnel policies. Apply Director of Nurses, St. Joseph's Hospital, Victoria, B.C.

Royal Jubilee Hospital, Victoria, B.C. invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary $227.50-$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

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General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital. Good personnel policies. Starting salary: $215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

General Duty Nurses for 60-bed General Hospital. Good salary & personnel policies. 44-hr. wk. All statutory holidays. Sick leave allowance. Apply Supt., Public Hospital, Smiths Falls, Ontario.

General Duty Nurses as soon as possible. Gross starting salary: $225 per mo. with automatic increases semi-annually for 2 yrs. 44-hr., 5½ day wk. 1 mo. vacation with pay after 1 yr. service. All statutory holidays. Separate nurses' home. For further information apply to the Matron, Lloydminster Hospital, Lloydminster, Sask.

General Duty Nurses for 466-bed hospital. Salary: $300 California registered, $270 Canadian registered. $15 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, California.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: $288-$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

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Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $300 with 4 annual increases to $341. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses for 312-bed General Hospital. Salary: $295-$341 per mo. Apply Merced County Personnel Department, Courts Building, Merced, California.

Staff Nurses for 500-bed General Hospital. Beginning salary: $300 per mo. with advancement to $335 for those eligible for registration in the state of Michigan. Additional differential $1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

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Staff Nurses for 225-bed General Hospital, on outskirts of New York City. Salary: $240-$280. $30 for permanent evening duty, $25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

Graduate Nurses (4)for permanent staff Municipal Hospital. Net salary $180 per mo. with full maintenance. At the end of each 6-mo. period on staff Graduate nurses will receive a bonus of $120 thus making the net salary in effect $200 per mo. before income tax. 2 day vacation time is earned each full mo. worked, 8 statutory holidays in addition. Liberal sick pay & free hospitalization included in plan. We have a very nice residence for the nursing staff & are only 2 hrs. from Calgary by Trans-Canada highway or C.P.R. main line. You will like it here. Apply Matron, Municipal Hospital, Bassano, Alta.

Graduate Nurse for 18-bed General Hospital, situated on the beautiful Arrow Lakes. Standard salaries. Holidays. 40-hr. wk. Apply Matron, Arrow Lakes Hospital, Nakusp, B.C.

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Assistant Graduate Nurse (Immediately) for the Wainwright Clinic. Please state qualifications & salary expected. Apply to Drawer 693, Wainwright, Alberta.

Graduate Nurses for new 21-bed hospital. Salary: $250 per mo. $45 room & board. 4-wk. vacation after 1 yr. Apply Matron, Queen Charlotte Islands General Hospital, United Church of Canada, Queen Charlotte City, British Columbia.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron Terrace & District Hospital, Terrace, British Columbia.

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- Appointment to service of your choice.
- Good personnel policies with above average salary schedule.

Supervisors — $260 increasing to $310
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Extra allowances for postgraduate training.

Apply Director of Nursing:

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TORONTO 15, ONTARIO

Graduate Nurses (General Staff Positions) for General Hospital. Salary: $239. per mo. as minimum & $277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate Nurses for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

Graduate Nurses for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Operating Room Nurses (2) for 60-bed General Hospital. Good salary. 5½ day wk. Statutory Holidays. Apply Supt., Leamington District Memorial Hospital, Leamington, Ont.

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- Service de Transfusion.
- Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

DIRECTRICE NATIONALE, SERVICE DU NURSING,
LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE,
95 RUE WELLESLEY, TORONTO 5, ONTARIO, CANADA.

SOUTHWEST REGIONAL HOSPITAL COUNCIL

Graduate Nurses are invited to make application for the following vacancies in sunny southwest Saskatchewan, the centre of wheat growing and ranching:

Climax-Bracken Union
1 G.D. Nurse, $255

Frontier Municipal
1 G.D. Nurse, $230 - $260

Gull Lake Union
1 G.D. Nurse, $230 - $260

Shaunavon Union
1 O.R. Nurse, $250 - $280
2 G.D. Nurses, $230 - $260

Swift Current Union (115-beds)
3 G.D. Nurses, $220 - $250

Further details of excellent conditions of service may be obtained from the Director of Nursing at the individual hospital or from the undersigned:

PHILIP RICKARD, REGIONAL HOSPITAL CO-ORDINATOR,
SWIFT CURRENT, SASKATCHEWAN

Operating Room nurse. Postgraduate training not essential. A.N.P.Q. salary scale in effect. All graduate staff. 8-hr. day; 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

Supervisor (qualified.) Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

PEDIATRIC INSTRUCTOR

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

For further information apply:

DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.

GENERAL STAFF and PSYCHIATRIC NURSES

Required to staff

New wing of 350-bed General Hospital.

Basic salary: $250 per mo. with yearly increments of $120 for 3 years.

Differential for evening & night duty.

For further information apply to:

DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL
1995 LENS AVENUE, WINDSOR, ONTARIO

Public Health Nurse (Qualified) for generalized program. Salary: $3,000-$3,600 depending on experience. Annual increment $150. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

Public Health Nurse (1) for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King. York County Health Unit, Newmarket, Ont.

Public Health Nurses (2) for generalized program in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: $3,000 for inexperienced nurses to start with annual increments of $150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

Public Health Nurses (qualified.) Salary: $3,100 depending on dist. served, less if in the Timmins area. Annual increment $150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurses (Qualified) for a generalized program in Etobicoke Township (suburb of Toronto.) Minimum salary: $3,200. Annual increments to $3,680. Starting salary based on experience. Car allowance $670 per annum. 4 wk. vacation after 1 yr. Blue Cross & Pension Plan. Apply Director of Public Health Nursing, Township of Etobicoke 4946 Dundas St. W., Toronto 18, Ont.

Registered General Duty Nurse for modern 21-bed hospital situated 4 mi. from beautiful Peace River Valley & 5 mi. from beach & resort on Cardinal Lake. Good bus, train & aeroplane service. Salary: $240. Increase $5.00 every 6 mo. to $270 max. Full maintenance available for $25. Apply Sec., Municipal Hospital, Berwyn, Alta.

Registered Nurses (2) on or before November 15th for new, modern 15-bed hospital. Salary: $230 per mo. with $25 deducted for full maintenance. $180 bonus plus 1 mo. vacation after 1 yr. continuous service. New & fully modern nurses' residence. Apply Matron, Union Hospital, Maidstone, Sask.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

The
Ontario Society for Crippled Children

requires

EXPERIENCED PUBLIC HEALTH NURSES

GOOD SALARY RANGE

and

PERSONNEL POLICIES

For further information apply to:

THE SUPERVISOR OF NURSING SERVICES,
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,
92 COLLEGE STREET, TORONTO 2, ONTARIO

Obstetrical Supervisor, General Duty Nurses (Immediately) for 40-bed General Hospital. Good salary & personnel policies. Living accommodations available. Apply Supt., Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

Staff Nurses (1 or 2) for fully modern 14-bed hospital. Salary: $225 per mo. gross plus bonus. 3-wk. vacation & 8 statutory holidays. All transportation costs refunded on completion of 1 yr. service. Apply Mrs. E. O. Kunkel, Matron, Union Hospital, Coronach, Saskatchewan.

Public Health Nurse (Experienced) for senior position, generalized public health nursing. Salary: $3,750 per yr. 5-day wk., sick pay benefits, Blue Cross, P.S.I. Car allowance. Apply J. H. Miller, Municipal Clerk, Town of New Toronto, 185 Fifth St., New Toronto, Ont.

Head Nurse (Central Supply), Science Instructor for 200-bed General Hospital. School of Nursing, September classes only. 40-hr. wk., 1 mo. annual vacation, 10 statutory holidays. 1½ days sick leave per mo., cumulative. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses & Certified Nursing Assistants (Immediately). Residence accommodation. Personnel policies. Situated 25 miles from Toronto. Apply Director of Nursing, Peel Memorial Hospital, Brampton, Ontario.

Registered Nurses for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: $290 for 40-hr. wk., $10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

REGISTERED NURSES
$2,610-$3,360

CERTIFIED NURSING ASSISTANTS
$2,040-$2,220

WESTMINSTER HOSPITAL 5-day week **SUNNYBROOK HOSPITAL**
TORONTO **LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

CIVIL SERVICE COMMISSION,
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO

DIRECTOR OF NURSING

for

VICTORIA HOSPITAL, RENFREW, ONTARIO

Approximately 100-Beds School of Nursing with 30-40 students.

ATTRACTIVE OTTAWA VALLEY TOWN, 60 MILES FROM OTTAWA

SALARY: $400 PER MONTH

3-room Apt. available if Director wishes to live in residence.

Qualifications desired: Degree or postgraduate certification in nursing administration.

Apply giving experience & qualifications to:

CHAIRMAN, PERSONNEL COMMITTEE, VICTORIA HOSPITAL, RENFREW, ONTARIO

General Duty Nurses (2) for 20-bed modern hospital. Salary: $200 per mo. plus full maintenance. Usual holidays with pay, sick leave etc. Fare refunded one way after 1 yr. Separate modern nurses' home. Apply Matron, Union Hospital, Vanguard, Sask.

General Duty Nurse on surgical floor. Liberal personnel policies. Residence facilities available. Apply Director of Nursing, Sudbury & Algoma Sanatorium, Box 40, Sudbury, Ontario.

Registered Nurses (Under age 50) General Duty: $300-$350 (5 steps.) **Head Nurses:** $315-$375 (5 steps.) Retirement plan, sick leave benefits. 3-wks. vacation, holidays. Modern nurses' residences. State eligibility for California registration. Rehabilitation ward recently opened. Tuberculosis, other chest diseases, chronic illness. Interesting & challenging positions for qualified registered nurses. Submit photo to Director of Nursing Services, Tulare-Kings Counties Hospital, Springville, California.

Under the sponsorship of the Council for Clinical Training, an interdenominational Protestant organization, clergymen are taking "clinical internship" at hospitals and similar institutions. By observation, through lectures and by sitting in on diagnostic conferences for new admissions, the clergymen become familiar with the structures and disorders of the body's main systems. They live with residents and interns for 3-month training periods during which time the physicians build up a more positive feeling towards the chaplain's role in the hospital. The clergy in turn learn how to cooperate with the doctors.

— *Scope*

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $220 to $260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

POSITIONS WANTED

Available — Experienced Registered Public Health Nurse (University of Toronto) seeks position in congenial surroundings offering challenge, responsibility & advancement opportunities. Apply Box J, The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Que.

Science Instructor, university diploma, experienced in planning whole teaching program seeks position. Apply giving full particulars to Box K, The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal, Que.

DIETITIAN

FOR

VICTORIA HOSPITAL, RENFREW, ONTARIO

APPROXIMATELY 100-BEDS

Attractive Ottawa Valley Town, 60 miles from Ottawa.

SCHOOL OF NURSING WITH 30-40 STUDENTS

State qualifications, experience and salary expected.

Apply, with references to

CHAIRMAN, PERSONNEL COMMITTEE, VICTORIA HOSPITAL, RENFREW, ONTARIO

REGISTERED NURSES

required for General Duty

at

HALDIMAND WAR MEMORIAL HOSPITAL

For further information write to:

***Director of Nursing*, Haldimand War Memorial Hospital, Dunnville, Ont.**

WESTERN MEMORIAL HOSPITAL

Corner Brook, Newfoundland

requires immediately

OPERATING ROOM NURSES

For modern well equipped Operating Room. Good conditions of service. Return fare paid by hospitals after completion of 1 yr's. service.

Apply: SUPERINTENDENT OF NURSES

THE KINGSTON GENERAL HOSPITAL

requires

For its New — 81-bed Pediatric Section

PEDIATRIC SUPERVISOR

and

PEDIATRIC INSTRUCTOR

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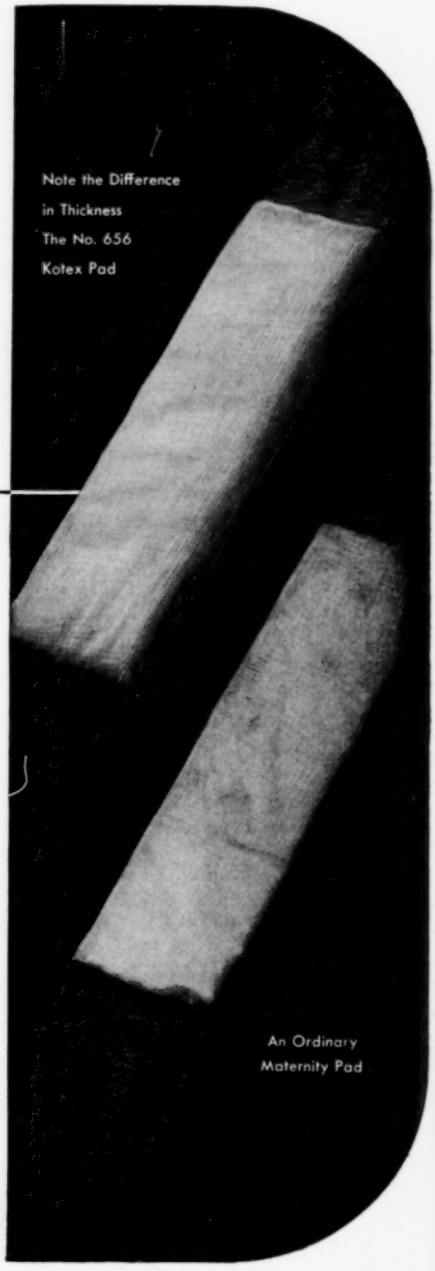

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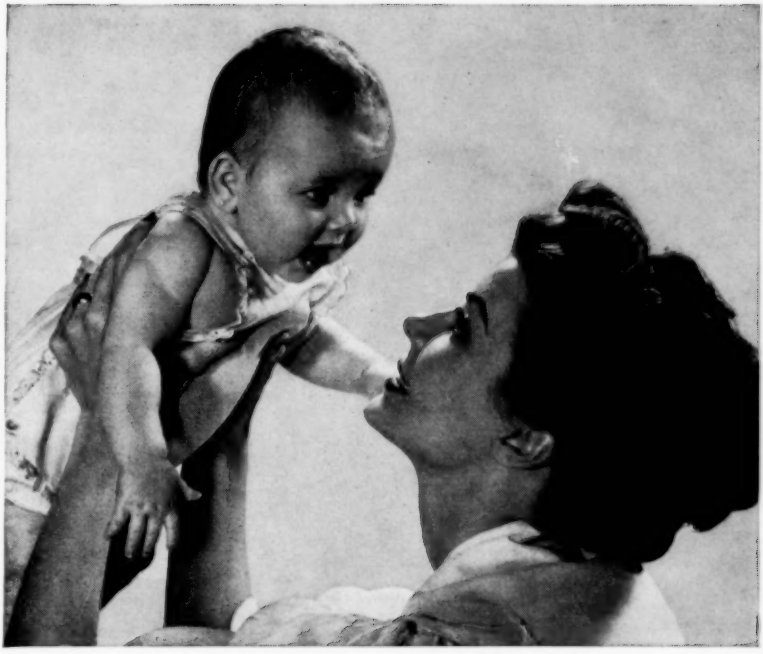

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